Mentors' experiences of supporting pre-registration nursing students : a grounded-theory study

Thesis

Mentors' Experiences of Supporting Pre-registration Nursing Students - A Grounded Theory Study

HELEN WISDOM, BSC (HONS), MED.

Doctorate in Education

Discipline of Education
The Open University

October 2011

Acknowledgements

My thanks go to the mentors who participated in this project. I would also like to sincerely thank my supervisors Jenny Spouse and Fiona Reeve for their help and encouragement. I thank my colleagues for their support, especially Andrew. To my husband Peter, and daughters Claire and Anne, thank you for your patience.

I am grateful to colleagues at Robert Gordon University for their help and my thanks go to The Florence Nightingale Foundation for the research scholarship sponsored by The University College Hospital Nurses' League.

Helen Wisdom

Contents

List of Tables

List of Appendices

Abstract

This study explores the experiences of mentors who support pre-registration nursing students in clinical practice. The research was conducted in a remote and rural Scottish Health Board area. It poses the question, 'What role do mentors play in facilitating learning in practice?' Sub-questions explore how mentors see their role in promoting students' professional development, how they support students across the four domains of practice identified by the NMC (2004), and what factors impact upon mentors' abilities to promote student learning.

An interpretative approach was adopted, guided by the principles of grounded theory (Strauss and Corbin, 1998). The theoretical framework drew upon social learning theories in helping to explain how possibilities for learning are dependent upon the social situation, social practices and student admission to 'communities of practice' (Lave and Wenger, 1991).

The key data collection method was that of interview. 10 mentor volunteers were interviewed on two occasions, 8 of these mentors also kept diaries of their mentoring activities and reflections over a 12 week period.

Findings led to the development of a tentative theory 'Fostering student learning' in which mentors facilitated the learning and development of their mentees in a supportive atmosphere likened to that of a nurturing family. The quality of the personal relationship between mentor and mentee was important as mentors established on-going dialogue with their mentees and 'coached' them towards achieving proficiency, instilling in them the values of kindness, compassion and a

1	Student details	Your full name: Helen Wisdom Personal identifier (PI): M2072553 Affiliated Research Centre (ARC) (if applicable): N/A Department: Education Thesis title: Mentors' Experiences of Supporting Pre-registration Nursing Students - A Grounded Theory Study
2	Authorisation statement	I confirm that I am willing for my thesis to be made available to readers by The Open University Library, and that it may be photocopied, subject to the discretion of the Librarian Signed: Hwisdom Print name: Helen Wisdom
		Date: 14/09/2012 DD/MM/YY
3	British Library Authorisation (PhD and EdD candidates only)	The Open University has agreed that a copy of your thesis can be made available on loan to the British Library Thesis Service on a voluntary basis. Please indicate your preference below: ☒ I am willing for The Open University to loan the British Library a copy of my thesis OR ☐ I do not wish The Open University to loan the British Library a copy of my thesis

pride in the profession. In clinical placements in remote settings the pastoral role of the mentor appeared heightened and this added to the pressure mentors experienced as they sometimes struggled to balance competing responsibilities. The role of mentor is vital to supporting student learning, it has significant impact upon those who undertake it. A number of recommendations are made concerned with strengthening the mentor role.

1. Introduction

Presenting a rationale for this research

My interest in workplace learning can be traced back to my experiences as a student nurse some four decades ago. Student nurses were then considered part of the workforce and learned 'on the job' in an apprenticeship model described as 'sitting by Nellie'. Despite the passage of years, I still find it easy to recall the powerful learning experiences of this period, both positive and negative. These were largely dependent upon the very variable calibre of 'Nellie'! I have never since been in any doubt of the significance of the role of the 'mentor' in clinical learning, reinforced when I held the role. Today I am employed as a Practice Educator in a National Health Service (NHS) Scottish Health Board area, in a remote and rural island setting. I have responsibility for ensuring that pre-registration nursing students, on clinical placement from mainland universities, are well supported. I wanted to enhance my understanding of workplace learning so that in my Practice Educator role I could do my best to support mentors' facilitation of student learning. Evidence suggests the key role that poor clinical placement experience plays in influencing students' decisions to quit their programmes of study (RCN, 2008). In undertaking this project my aim was to ultimately help avoid such poor experiences occurring within my own Health Board area.

Nursing is a fundamentally skills based profession and the workplace is considered to be essential in providing nursing students with an authentic work context in which to learn and develop. Within nursing the focus on workplace learning was increased when a commission investigating nurse education published its findings in 1999. The report 'Fitness for Practice' (United Kingdom Central Council (UKCC) for Nursing, Midwifery and Health Visiting, 1999) recommended that learning should occur in the practice setting for at least 50 per cent of pre-registration education programmes. In part this was an effort to redress criticism that nursing had become too theoretically focused when nursing and midwifery education was moved from hospital based schools into higher education in the 1990s. The Nursing and Midwifery Council (NMC), the statutory regulatory body for the nursing and midwifery professions, has stated that this 50 per cent balance between theory and practice will continue for all newly approved programmes (NMC, 2010). The quality of experience gained on clinical placement will therefore remain a very significant aspect of students' learning. Mentors have an important part to play in contributing to effective practice placement experience. The role of mentor attained greater prominence and was brought into very sharp focus indeed with the publication, 'Standards to support learning and assessment in practice' (NMC, 2006), revised in 2008 (NMC, 2008a). This document set out clearly the role and remit of the mentor. Mentors and 'sign off' mentors were to take responsibility for facilitating student learning in clinical practice and for assessing student competency. Given this enhanced role, the quality of mentoring that students receive has never been of more significance in determining the future of the profession. This increased emphasis on mentorship and increased recognition of the importance of clinical learning was a prompt for me to explore this area as my research topic.

A further prompt to this study occurred when I conducted a small investigation into students' perceptions of their experiences of learning whilst on clinical placement, as part of The Open University MEd module E835. Students provided me with insights into the complexities inherent in the mentor-mentee relationship, and I wanted to explore these in more depth. I also saw this project as a means of developing professionally, enhancing my knowledge of the research process so that I could advise students with more confidence. On a personal level, I relished the challenge of study at doctoral level, which if successfully concluded would enhance my self-esteem.

A Mentor survey – a further stimulus to this study

A major aspect of my Practice Educator role is to ensure that clinical placements for nursing students comply with the Quality Standards for Practice Placements (National Health Service Education for Scotland (NES), 2008). These standards derive from the Quality Assurance Agency (QAA) Code of Practice precepts for Placement Learning (QAA, 2007). They are the standards against which mentor activity is assessed both locally and nationally and provide a framework by which the quality of clinical placements can be judged. In order to audit compliance with these national standards I devised a questionnaire (Appendix 1) and distributed it to all 100 names on our local register of mentors. Low response rates are often a feature of postal questionnaires (Bryman, 2008) and my survey achieved a disappointing response rate of 39%, considered not acceptable by Mangione (1995). There is an increased risk of bias in survey results with low response rates, as there may be differences between participants and non-responders. Whilst my questionnaire results could not stand up to statistical scrutiny for this

reason, they did provide an overview of the mentoring experience of those that responded (Appendix 2). The quantitative data that was generated provided information on mentor experience prior to, during and after student placement. For example, some mentors seemed to be indicating that they did not always have time for student induction on day one and that they did not always deliver care with their student at least two times each week. Some thought that support was available for them and yet were unsure about systems that were in place for them to feedback their mentoring experiences. The use of questionnaires as a data gathering tool has disadvantages. Those who return questionnaires anonymously cannot be approached individually so that queries can be followed up. I wanted to be able to probe mentors to find out more about some of the issues raised. The qualitative data provided by participants in the 'open response' sections of the questionnaire particularly captured my interest. These snapshots of their world offered a tantalising glimpse of what it is to be a mentor. For example,

> *I have newly qualified in role of mentor but I am eager to pass on my skills, knowledge and information.* Questionnaire 4

> *It is always encouraging to see growth... it helps us jaded oldies remember why we chose this profession.* Questionnaire 11

> *My biggest concern is time - with the reduction in staff numbers, I fear that mentoring will be placed under increasing strain.* Questionnaire 16

These open responses reinforced the value of undertaking structured research into the mentor perspective. Mentors hinted at their aspirations, motivations and

frustrations and I wanted to explore them in more depth so that I could better understand their experience and provide appropriate support for them.

Educational Theory and Nurse Education - Background to the study

Before embarking upon this research, I thought it important to review general education theories to help provide a background to this study, contributing to my knowledge of how learning might occur in clinical settings. No single, all-encompassing theory of adult learning exists. Burnard (1990, p. 349) states that the search for such an 'educational golden fleece' is on-going. In the meantime, there is a range of theories contributing to the understanding of how learning takes place. Mentors need to facilitate student learning in a range of ways to help mentees to achieve NMC (2004) proficiencies. Students must gain knowledge and understanding of their subject, for example anatomy and physiology, so they know how the human body functions. They must demonstrate problem solving skills, for example, recognising and responding appropriately to abnormal behaviour. They need to develop clinical skills such as wound dressing and they must learn how to conduct themselves in an appropriate, professional manner when faced with difficult issues in clinical practice, for instance, supporting bereaved families. Mentors must flexibly adopt a range of approaches to meet these needs.

Situated learning

Much of our thinking about learning and education is based on the principal that learning is something that individuals do, and that it is the result of a discrete

teaching episode, often based in a classroom (Felstead et al., 2005). Jean Lave, a social anthropologist, and Etienne Wenger, an educationalist, present a very different perspective (Lave and Wenger, 1991), important in helping to unravel the complexity of how learning occurs in clinical practice. They argue that it is the social situation, social practices and social relationships that create the possibilities for learning, and that these are presented continuously as we engage in daily human activity. In this view, effective socialisation within a 'community of practice' is essential to attaining what they term 'legitimate participant status', it is this that provides access to learning.

The 'community of practice' is a rather diffuse concept, far wider ranging than the physical environment to which student nurses might be allocated for their clinical placement. For Lave and Wenger the 'community' does not necessarily mean a well-defined, identifiable group. Rather they describe it as 'a set of relations among persons, activity and world, over time and in relation with other tangential and overlapping communities of practice' (Lave and Wenger, 2002, p.115). The community of practice is therefore not confined by place or time, nor is it just concerned with the acquisition of technical knowledge or skill, important though these aspects are. They view it as, 'an activity system about which participants share understandings concerning what they are doing and what that means for their lives and for their communities' (Lave and Wenger, 2002, p.115). Newcomers need to 'absorb' and be 'absorbed into' the culture of practice (Lave and Wenger, 2002, p.113). For a student nurse this would involve gaining an in-depth understanding of what it is to be a registered nurse and what accepted standards of behaviour are. Students need to understand how registered nurses

'talk, walk, work and generally conduct their lives' (Lave and Wenger, 2002, p.113).

Socio cultural theories

The work of Vygotsky (1896-1934), a Russian scholar, has much to offer when considering neophyte nurses and how they learn in clinical settings. Spouse (1998a) draws upon socio-cultural theories of human learning to explain her findings when investigating nursing students and uses concepts such as the Zone of Proximal Development (ZPD), 'scaffolding' and 'fading' to explain how her participants seemed to integrate theory and practice. These concepts have their origins in the theories of Vygotsky (1986).

Vygotsky introduced the notion of the Zone of Proximal Development (ZPD) in his book, 'Thinking and speech' in 1934 (Wertsch, 1985) as the range of tasks that are too difficult to do alone but which can be managed with guidance. In the field of child development, they are those functions that have not yet matured but are in the process of maturing. As a task becomes more familiar to a child and more within its competence, those who provide the 'scaffold' leave more for the child to do, 'fading' the support that they provide, until the child can perform the task competently. In a similar way, mentors must first assess the boundaries of a student's knowledge. They must gauge the extent to which the student needs to be 'scaffolded' to help them progress through their ZPD and to meet the learning outcomes agreed by both at the start of the clinical placement. For example, the mentor might 'scaffold' a student in performing a complex wound dressing, 'talking them through' the procedure in detail until the student gains confidence and the

support from the mentor is gradually withdrawn or 'fades'. Thus, the mentor must make a complex formative assessment of the student's competence and set learning objectives that will 'scaffold' their learning in order to help them advance. Scaffolding is an important strategy for mentors to adopt when guiding novices in attaining new skills and knowledge (Spouse, 1998a). Cope et al. (2000) concur with Spouse stating that one of the defining characteristics of 'cognitive apprenticeship' is the way in which experts make their situational knowledge explicit as they coach the learner and strategies such as scaffolding and fading are an important means of doing so. In other words they must be concerned with the process of learning in order to achieve the required outcome.

Vygotsky and social theorists argue that for students to learn effectively in the workplace they need to be guided towards learning experiences appropriate for their stage of training. They need to be conversed with in language that they can understand where professional terminology and jargon is not used as a means of excluding them. Vygotsky emphasized the roles of cultural and social factors in cognition, arguing that social interaction and speech were instrumental to human development and learning and that language was the most important symbolic tool provided by society. It can be argued that the professional development of nursing students is also dependent upon social interaction and language use (Spouse, 1998b). Vygotsky (1986) explored the inter-relationship of language, development and thought and made explicit the connection between speech, both silent, inner speech and oral speech, and the development of mental concepts and cognitive awareness. He believed that intrapersonal speech was qualitatively different from interpersonal speech, the former having developed from external speech by a gradual process of internalisation. Vygotsky argued that intrapersonal speech

promotes higher mental functions such as problem solving and the development of conceptual frameworks and can be used as an internal organizer of activity. This is evidenced when a nursing student is undertaking an unfamiliar task, for instance dispensing medication and can be heard 'thinking out loud'. In such a case the student is using an internal voice to act as their own personal guide or coach to help them gain proficiency in conducting a new procedure or in utilising the vocabulary of new knowledge. As mature learners we can self-instruct and 'scaffold' ourselves through difficult tasks. Others may have 'scaffolded' us during earlier attempts. Vygotsky was concerned with the social origins of human development, unlike Piaget who held that social development was dependent upon the stage of physical development (Spouse, 1998a).

A number of parallels can be drawn between Piaget's theories (1950, cited in Atkinson et al., 2000) regarding the development of intelligence in children and how mentors support students in practice. Piaget argued that cognitive development in children progresses through a series of hierarchical, qualitatively different stages. Teachers must provide children with appropriate learning opportunities so that they can progress to the next developmental step; they must consider the child's state of 'readiness to learn'. In a similar way, mentors must adopt a 'student centred' approach and provide appropriate learning opportunities for students in the clinical setting, mapped to their stage in their education programme. To do otherwise might expose students to situations for which they are unprepared. This might leave them feeling thrown in 'at the deep end', unable to cope and their confidence undermined. For example, expecting a junior student to inform relatives of the death of a patient would be inappropriate in most

instances, and might result in the student feeling traumatised, unable to learn in such circumstances.

Mentors have an important role to play in helping students to relate theory to the practice they see on clinical placement and vice versa. In helping students to learn they need to encourage students to make links and understand relationships within and between subjects (Spouse, 1998b). Jerome Bruner (1966) argued that educators need to provide learners with the means of grasping the underlying principles and concepts of a subject, rather than just mastering factual information. This allows students to develop their own ideas and go beyond what has been taught. For example, a student may be taught by her mentor how to wash her hands and become very skilled at hand hygiene. However, in order for the student to apply her newly gained skills appropriately in all situations, she must have an underpinning knowledge of infection control principles. Bruner (1966) had an important role to play in extending Vygotsky's ideas and applying them specifically in an educational context. He stressed the role of language and interpersonal communication, especially in the 'scaffolding' process. It was Bruner and his colleagues who coined the term 'scaffolding' (Wood et al., 1976, p.90). Unlike Piaget, Bruner did not identify 'stages of development', as such. He describes three modes of representing the world; they are enactive (action based), iconic (image based) and symbolic (language based). These are not neatly delineated stages; they are integrated and translate into each other. This is the crux of the 'spiral curriculum' where a subject comes to be learned at increasingly complex levels of difficulty. For example, nursing students are introduced to basic hand hygiene early in their programme but progress to the complexities of microbiology in the latter stages. The mentors' role is to help relate theory to the practice they

engage with on clinical placement. Ultimately, this is about helping students to achieve a deep level of learning, to understand the meaning, rather than just having a superficial knowledge of the subject (Marton and Saljo, 1976).

Theories of Adult Learning

I considered adult learning theories for what they might add to my understanding of learning in clinical practice. 'Andragogy' is defined as the art and science of helping adults learn. It is most closely associated with the work of Knowles (1998). At the heart of this model is the way in which learners are regarded. Knowles stresses the significance of the prior experience that learners bring to education, making them a rich resource for peers and teachers alike. It is possible to envisage a neophyte nurse making a contribution as a result of their own experience, perhaps as a patient, or bringing a new perspective from their experiences as a Health Care Support Worker. However, as very new recruits to the profession it is difficult to see them using prior knowledge as a 'rich resource' for colleagues in each clinical speciality.

In Knowles's andragogical model adults are self-directed in their learning. They become ready to learn when they need to know something and they need to be able to apply what they learn. Nursing students should have a powerful impetus to learn in that they have chosen to enter the profession and their goal is to gain registered nurse status by achieving the proficiencies required by the NMC (2004). In clinical practice they have the opportunity to directly apply this learning. For adults, self-concept is often affected by what is learned. This self-concept moves from dependency to independency as individuals grow in confidence. The role of

mentor is important in helping students progress from a state of almost total reliance upon them to independent working, when they can 'fly solo' (Spouse, 1998a, p. 265).

The Humanist perspective

Humanist learning theories have a contribution to make in understanding how nursing students learn in clinical practice (Burnard, 1990). A key principle of humanist education is an emphasis on respecting the individual who is seen as being motivated by an urge to learn from within themselves. In this paradigm the learner is seeking personal growth and development for their own sake, the focus is on the experience of learning. To help in this aim the student requires a facilitator to guide them towards achieving goals and objectives, rather than a 'teacher' who attempts to directly transmit knowledge, for instance by means of a lecture. Within this view there is an emphasis on the active learner who must take control of their own learning amidst a world of complexity and change. Nursing students have chosen to undertake a programme of study and should therefore be self-motivated to meet the goal of attaining registration with the NMC. The mentor is the facilitator and guide in helping the student to achieve this objective amidst the uncertainty and change experienced in modern health care delivery.

The humanist perspective and the educational theories generated by it have had a huge impact upon the way that pre-registration nursing programmes are designed and delivered. Milligan (1998) argues that in the socialisation process inherent in nurse education, care is difficult to teach or facilitate unless the philosophy and methods are consistent with such ends. Humanist educational principles,

asserting that education is about personal growth, underlie much of the remit of the mentor. Mentors are expected to 'facilitate personal and professional development of others' (NMC, 2008a, p. 20). In 1915, Dewey described education as 'a fostering, a nurturing and a cultivating process' (cited in Purdy, 1998, p.114). Nursing mentors take on this role for their students, providing learning experiences for them, assessing them, providing feedback and acting as role models for them. They hold a central position in helping students to develop professionally and personally. Rogers (1967) claims that the personal relationship between facilitator and learner is paramount in the initiation of learning. This is borne out in the nursing literature, which reveals the importance of the personal relationship between mentor and student to the success of the mentoring process (Spouse, 1998b, 2001a, 2001b, Gray and Smith, 2000). Rogers (2002) advocates the establishment of a community of learning in which the learner is 'prized', accepted, trusted and valued as an individual. These humanist theories with their emphasis on the individual, personality and the circumstances of learning go some way to enhancing understanding of the ways in which nursing students can be helped to learn in the workplace. However, there has to be an acknowledgement that whilst the ideal is for the learner to be 'prized', in the busy health care environment this is not always the case and the literature bears witness to often poor student experiences on clinical placement (Gray and Smith, 2000).

Student learning can be seen as a complex amalgam partially explained by a range of educational theories. All make a contribution in helping to explain what occurs in clinical practice. Given that nursing students' placements are within clinical teams, the work of Lave and Wenger (1991) seems particularly pertinent, offering a perspective in which it is the social situation and social practices that

create the possibilities for learning. Humanist theories help in an appreciation of the facilitative role that mentors play in guiding students to achieve their learning objectives.

An overview of this thesis

In this introductory chapter I have provided a rationale for this study, derived from both professional and more personal motivations. I began with a very broad and tentative research question, 'What are the experiences of mentors supporting pre-registration nursing students?' to help provide a framework in searching and reviewing the literature. My final and more detailed research questions arose as a result of this review, as described in **Chapter 2**. My research design is discussed in **Chapter 3,** where I present a rationale for how I decided to investigate my research questions, guided by the principles of a grounded theory approach. The results of my research are presented in **Chapter 4,** where I focus on the key themes that emerged from the data. In **Chapter 5**, I discuss my findings and present recommendations for future practice. **Chapter 6**, the concluding chapter, offers an evaluation of my project, its key findings, strengths and limitations. This final chapter ends with a personal reflection upon my own learning.

In this thesis I will be adopting the definition of a mentor defined by the NMC (2008a), as one who facilitates learning and supervises and assesses students in a practice setting. It will be used to encompass the terms clinical supervisor, practice supervisor, preceptor and the many titles that are used to describe those who undertake this role. The term 'clinical placement' is used to define a place

where learning opportunities are available for nursing students and where practice can take place under supervision.

2. Literature Review

In the previous chapter I set out my rationale for undertaking this study exploring the experiences of mentors supporting pre-registration nursing students. I described a range of both professional and personal motivations driving the research. In this chapter I present a review of the existing literature for what it can contribute to understanding of the role that mentors play in facilitating learning in practice.

I have organised my review structured under headings that aim to present an organised approach to the literature in terms of what it can offer in contributing to a broader understanding of how mentors support students. I begin with an account of how I accessed relevant literature and then present themes derived from it. I have concentrated first upon what the literature has to offer in helping to understand how the current role of nurse mentor has evolved over the years. I then explore what the literature can contribute to an appreciation of the qualities of an effective mentor and the value that mentors can add to learning in clinical practice. I move on to consider what the literature has to say about how effective working relationships are established between mentors and mentees and consider how mentors assess students and their accountability in so doing. This section ends with a review of the support that mentors say they need to help them carry out the role. Arising from this analysis of the literature I was able to develop my research questions and I present these in the final section of this chapter.

Searching the literature

In order to identify relevant studies the literature was accessed via the 'The Knowledge Network', previously known as NHS Scotland 'e-library'. This is an online resource (www.knowledge.scot.nhs.uk) available to all NHS staff in Scotland, giving access to 12 million information and learning resources from 100 providers. It allows searching across all the major databases, including ASSIA, CINAHL, Medline, BNI, OVID and AMED. For my initial review of the mentoring literature I set very broad inclusion criteria as I wished to enhance my knowledge of the role generally and gain a broad overall sense of how the mentor role had developed. Burgess et al. (2006) discuss the importance of the exploration of a wide range of texts to establish background to a study. This can then lead to a progressive focus on those areas where research information is deficient. As I was contemplating the use of grounded theory methodology I was conscious of the advice of Strauss and Corbin (1998) who state that there is no need for an exhaustive search of the literature in the early stages of a project. They argue that it is impossible to know what will emerge from the investigation and that researchers must not be 'constrained and even stifled by the literature' (Strauss and Corbin, 1998, p. 49). However, I thought it important to identify the range and types of previous research to provide a background to my research and to help establish its importance. It was also a requirement of the Open University EdD programme to conduct a literature review at this stage.

Looking at the databases, it was immediately apparent that terminology relating to mentorship was diverse, with titles such as mentor, preceptor, practice supervisor and clinical supervisor being used synonymously. I therefore used these titles as

my search terms combined with 'pre-registration nursing' in conducting my searches. I followed up citations in the most pertinent literature and accessed relevant websites such as the Nursing and Midwifery Council (www.nmc-uk.org), Royal College of Nursing (www.rcn.org), Department of Health (www.dh.gov.uk) and the Scottish Government (http://home.scotland.gov.uk). The concept of mentorship relating to nursing seems to have emerged from the USA (Darling, 1984, 1985). I considered literature within this timescale focusing on UK studies that began to appear in the early 1990s when formal support mechanisms started to be reported. Of most significance to my project were studies following the introduction of Project 2000, when mentoring was accorded more significance for pre-registration nursing students. I reviewed the literature regularly throughout the research process.

Reviewing the literature has been problematic. Titles used to describe various support roles were often used interchangeably though there were differences described in roles and responsibilities, a fact I had to bear in mind when comparing studies. There were also major changes to consider in the pre-registration nursing programmes over the years and developments in the mentor role in consequence. I had to consider whether or not direct comparisons across time were appropriate given these changing circumstances.

Mentorship in Nursing

The role of the mentor in nursing has become very significant. Mentors have a vital contribution to make as they are now required to support students to achieve learning objectives in clinical placements, passing on their skills and knowledge

and helping students to develop appropriate professional behaviours. When the NMC published 'Standards to support learning and assessment in practice' (NMC, 2006) mentors' existing responsibilities were formalised by introducing 'sign off' mentors, who carry accountability for the decisions they make in admitting students to the professional register. Myall et al. (2008) note that in this respect the role of mentor is even more important than originally envisaged. In addition to their education and support role, mentors have an enhanced part to play in patient safety and public protection as they are the 'gatekeepers' to the profession.

The Evolution of Mentorship in Nursing

Here I review the literature relating to how the role of nurse mentor has evolved. I do this to provide a context in which to view the current role. In addition, mentors with long service have had the lived experience of these changing roles. Therefore, an understanding of this history might help in appreciating current perspectives of potential recruits to the study.

Whilst the origins of mentorship can be traced to ancient times, the term 'mentor' is now used in common parlance to describe a friend or role model to an often younger protégé. In the business world a mentor may smooth the career pathway of a new recruit. However, within the nursing profession, 'mentor' has a very specific meaning. The current role and remit is defined in detail by the NMC (2008a) and this represents the most recent manifestation of a role that has developed incrementally over many years. Pellat (2006) suggests that Florence Nightingale may have been the first nurse mentor but in the modern era the concept has been located to the USA in the 1980s, though in these early years

mentoring seems to have related mainly to post qualifying nurses. The literature bears evidence to an intense debate over the decades regarding the role and remit of those who support students in clinical practice in the UK. It reflects the radically changing expectations of the role in line with changes to nurse education. The move from an apprenticeship model to Project 2000 (UKCC, 1986) and then the changes brought about as a result of Fitness for Practice (UKCC, 1999) resulted in a change in emphasis on the mentor role. Mentors are now required to support students, who have supernumerary status, in achieving their learning objectives in clinical placement. This is a very different role to when students were part of the workforce and the emphasis was on learning by getting the work done. In consequence the role of mentor has increased in importance.

Historical development of the role

The statutory bodies played a part in directing the way in which the mentor role developed. The English National Board for Nursing, Midwifery and Health visiting (ENB) expected mentors to be 'wise and reliable counsellors' in 1987. In 1988 their advice was that the mentor would not normally be involved in assessment but by 1990 the role had been redefined so that the mentor could be all things to the student (Cahill, 1996). With the statutory bodies mandating that each pre-registration student should receive mentor support much of the early literature was descriptive and anecdotal, concerned with defining the role of mentor (Donovan, 1990, Morle, 1990, Armitage and Burnard, 1991). It was not until later that articles appeared that were research evidenced, the earliest UK study I have identified being Littlejohn (1992). This early study considered the effects of mentorship on

learners, though its contribution is limited due to the size of the study (n=4) and that it relates to 'pupil nurses'.

In these early years the profession was considering the remit of the mentor role. Consequently, the main thrust of debate centred on whether or not mentors could guide and nurture students and then objectively assess their performance (Clifford, 1994, Neary, 1997, 2000a, Bond and Holland, 1998). It was argued that the introduction of 'managerial' aspects, such as summative assessment into the role of mentor would result in role conflict and interfere with nurturing relationships (Armitage and Burnard, 1991, Anforth, 1992). For instance, a registered nurse participant of Neary's (1997) research described this conflict in terms of being either a friend or executioner. Neary's (1997) findings identified the potential for conflict in combining the two roles and importantly highlighted the poorly defined role of the mentor at this time and the confusion this generated. As Neary's research was based on a large sample size (n=300 nursing students, n= 155 practitioners) from 3 different college sites and utilised a range of data gathering tools, including interviews, questionnaires and non-participant observations, the findings can be regarded with confidence. Other authors contributed to the debate suggesting that the need to assess students would impinge upon a positive working relationship between mentor and learner, creating stress for learners due to fear of revealing weaknesses and fear of failure (Jarvis and Gibson, 1997). This was an interesting proposition. Even if it could be demonstrated that there is merit in separating the 'guiding and nurturing' aspect of the role from that of assessor, implementation would be problematic given the pressures of time faced by clinical staff in contemporary health care settings. The complexity of having different roles to consider prior to allocating students to mentors seems impractical.

Furthermore, it is hard to understand how professional guidance and advice could be provided to students without an assessment of their needs being made on an on-going basis. The other main strand for debate arising from this discussion concerned itself with whether or not students should be able to select their mentor. Advocates suggested that an element of choice in mentor-student pairings might improve the chances of success of the relationship (Anforth, 1992).

The current mentor role

The document 'Standards to support learning and assessment in practice' (NMC, 2008a) has replaced all previously published standards relating to student support. It is a clear declaration of the NMC's expectations of the role, in which both supportive and assessment elements are encompassed. Debate surrounding the remit of the role, which so exercised researchers and commentators in the past, has been resolved meantime. The standards present an unequivocal statement of expectations of the role and were introduced in an effort to bring much needed clarity. Their purpose was also to drive up the standard of mentorship to ensure that those admitted to the professional register were able to function at the required standard. They also provide recognition of the important role that clinically based professionals have in the education and training of recruits. To comply with these standards, achieving and then maintaining mentor status has now become a much more formalised process (NMC, 2008a). To be eligible, individuals must meet stage one criteria by complying with 'The Code, Standards of conduct, performance and ethics for nurses and midwives' (NMC, 2008b) by facilitating students and others to develop their competence. To act in a mentoring capacity they must meet stage 2 standards, demonstrating that they have

successfully achieved all of the outcomes of this stage (NMC, 2008a). To become a mentor an approved mentor preparation programme must be successfully completed (NES, 2007), following which, mentors names are added to the locally held mentor register, with existing mentors. To remain current, mentors must update annually, mentor at least 2 students in a 3 year period and declare that they have done so at a triennial review meeting with their line manager. The 'mentor standard', 'criteria for mentors' and 'competence and outcomes for a mentor' (NMC, 2008a, p. 19-20) represent the culmination of a long journey in the development of the mentor role over many years. They provide an unambiguous statement of mentors' accountability and responsibility (see **Table 2.1)** and consequently are intrinsic to considering the experiences of mentors supporting pre-registration nursing students.

Organising and co-ordinating student learning activities in practice
Supervising students in learning situations and providing them with constructive feedback on their achievements
Setting and monitoring achievement of realistic learning objectives
Assessing total performance–including skills, attitudes and behaviours
Providing evidence as required by programme providers of student achievement or lack of achievement
Liaising with others (e.g. mentors, sign-off mentors, practice facilitators, practice teachers, personal tutors, programme leaders) to provide feedback, identify any concerns about the student's performance and agree action as appropriate
Providing evidence for, or acting as, sign off mentors with regard to making decisions about achievement of proficiency at the end of the programme

Table 2.1 Mentors' accountability and responsibility (NMC, 2008a, p.19)

The value and effectiveness of the role of the mentor

Generally, the early literature, as discussed in the previous section, largely concerned itself with defining the role and remit of the mentor. Later studies

supplemented this earlier research by exploring the value and effectiveness of the role of mentor. It is this literature that I now discuss. I draw upon domains identified by the NMC (2008a) to help organise my review relating to establishing effective working relationships, facilitation of learning and assessment and accountability as areas most prominently identified in the literature.

Establishing effective working relationships

The NMC (2008a) standards provide clarity regarding the role and remit of the mentor. In order to carry out the role effectively mentors obviously need a very wide range of personal attributes and professional skills to equip them to deal with the range and complexity of the role they are expected to undertake. The success or otherwise of mentoring seems largely dependent upon interpersonal dimensions of the mentor mentee relationship. A systematic search of the literature led Wilkes (2006) to declare that the skills, qualities and attitude of individual mentors are of more importance to a positive practice placement than the learning environment. Now I present what the literature can provide in helping to unpick the qualities that are valued in an effective mentor.

Trying to define what constitutes an 'effective mentoring relationship' is quite difficult, given its complexity. A working definition might be that an effective relationship is one in which mentor and mentee work together in a mutually supportive way to achieve student learning outcomes. The significance of personal relationships has long been recognised as a key determinant of the success of mentoring. Early researchers attempted to describe the qualities of the 'perfect' mentor. For example, Piemme et al. (1986) suggest the following

attributes: patience, enthusiasm, knowledge, organising ability, positive attitude, non-threatening, non-judgemental, flexible, open minded, objective, sense of humour, maturity, mastery of clinical skills, assertive, advocate for learner, able to use resources, self-confident but knows own weaknesses, responsible, professional and respect for peers! It is hard to argue with the assertion that such a paragon, if they ever existed, might indeed be an excellent mentor. However, as Armitage and Burnard (1991) point out, such a list is of little real practical value other than perhaps as an indicator of the complex nature of the role.

Moving on to the relationship between mentor and mentee, researchers have tried to pin point the defining qualities of success. Darling (1984), an oft quoted American researcher, suggested three essential requirements, mutual attraction, mutual respect and investment of time and energy. Her research, based upon interviews with approximately 150 health care professionals, including 50 nurses who had mentors, can be criticised for the lack of detail provided in terms of participant selection and data analysis. Despite this she made an important contribution in opening up discussion about what it was that mentors actually did. She identified 14 specific roles, including challenger, feedback giver, eye opener, door opener, problem solver and career counsellor, important in helping to understand the dynamics of the mentor-mentee relationship.

This early work led to attempts to devise tools that might help select potential mentors and to 'match' suitable mentors and mentees. For instance, Darling's 'Measuring Mentor Potential (MMP) scale' and questionnaire arising from this was a means by which individuals could self-assess their mentoring potential. Mentoring could thus be reserved for those who could demonstrate a particular 'flair' or interest. Anforth (1992) suggested the use of a questionnaire to identify

common ground between mentor and mentee, though provides no template for such an instrument. Whilst the rationale underpinning such tools is laudable, the practical application is very limited. For instance, in my own small Health Board area, any element of choice in whether registered nurses take on the role or not tends to evaporate as placements are viable only when all registered nurses commit to the role. In such situations there is an expectation that providing level 2 standards (NMC, 2008a) are met, registered nurses will be mentors, and this is formalised in job descriptions. Given the complexity of human relationships there must be doubts surrounding the validity and reliability of tools, such as that suggested by Anforth (1992), to match mentors with students. Even if this were not the case, the logistical difficulties involved in administering questionnaires and achieving 'matches' in each clinical area would limit its usefulness.

Nursing students, on clinical placement have to deal with change and adaptation to new environments, an experience that some have described in terms of anxiety and dread (Phillips et al., 2000). How well such changes are negotiated seems to largely hinge on the quality of the personal relationships that are established. The literature attests to the view that what students seem to value beyond all else is a supportive relationship with their mentor. (Andrews and Chilton, 2000, Gray and Smith, 2000, Lloyd Jones et al., 2001, Spouse, 1998b, 2001b, Andrews and Roberts, 2003). I now consider what the literature has to say about the qualities that students value in their mentors.

Students appreciate mentors who value them as people; this seems to be of primary importance to them. It is of more significance than the rank that mentors hold, as illustrated in an early study by Earnshaw (1995) where students gravitated to junior staff, the C and D grades at the time of the study. These staff had fewer

managerial responsibilities, delivered 'hands on care' and consequently had frequent contact time with students and were willing to support them. These are factors highly prized by students. Significantly, Earnshaw noted that the relationship worked best when both parties contributed equally, recognising each other's strengths and weaknesses. Earnshaw's findings were based on a small convenience sample. He distributed 19 questionnaires, with a response rate of 58% (n=11), raising issues of respondent bias and bringing into question the validity of his findings. His study considered only the views of students and did not take into account in any detail the way in which mentors viewed their role.

Whilst mentors seem to consider the possession of a teaching or assessing qualification to be an important factor in their effectiveness, students are less certain and rate their mentors positively irrespective of the possession of such a qualification (Andrews and Chilton, 2000). It is the personal qualities of the mentor in their roles as 'eye opener, idea-bouncer and problem solver' that students found praiseworthy in Andrews and Chilton's study (2000, p.559). The authors interpreted this as an indication of the importance of mentoring as a personal process where formal teaching is less important and not a sole determinant of successful mentoring. This was a small pilot study conducted over a 3 month period, gathering the views about the mentoring process from registered nurses (n=22 mentors) and students (n=11 mentees). The authors acknowledge that their findings should be read with caution as they are based wholly on the mentors' and students' perceptions and are not generalizable.

Cahill (1996, p.794), reported that what appeared important to the students in her study was, 'not so much a clearly-defined mentor role but consistency, genuineness and respect'. Based upon only 16 participants, with data collected by

means of group discussion and follow up interviews, Cahill's research might be criticised for being non-representative, small and descriptive. This is in common with other research studies regarding mentorship, where sample sizes are often small, the researchers acknowledging that generalization is not the intention of the research, the findings being specific to the research participants under study.

That students value mentors who are interested in their learning, convey a genuine concern for them as individuals and prepare for their arrival in placement were key findings of Gray and Smith's (2000) study. This was a longitudinal cohort study using Grounded Theory to explore the impact of mentorship on nursing students. 10 students were interviewed on 5 occasions during the progress of their studies over a three year period on a Diploma of Higher Education in nursing programme. These students also kept diaries recording their reflections and a further 7 students participated in the study by means of diary only. This was a small study but the longitudinal element allowed the researchers to track the development of the mentor-mentee relationship. The findings suggested that the students soon lost their idealistic view of their mentor and were able to gain insights into the qualities they perceived as being required in an effective mentor. 'Good' mentors were deemed those who spent time with the student, had good teaching and communication skills and paced their teaching to meet students' needs. Conversely, poor mentors broke promises, lacked knowledge and had poor teaching skills, with no structure to their teaching. They delegated unwanted tasks to the student and either 'threw them in at the deep end' or were excessively overprotective. Students noted that poor mentors often disliked their jobs and other members of the team disliked them. Again, emphasis on the personal qualities of the relationship was apparent, with words and phrases such as 'support', 'encourage', 'allow', 'a relaxed relationship', 'look out for them'

and 'confidence and trust' predominating in descriptions of the valued characteristics of mentors. In a review of 159 studies, Ehrich et al. (2002) noted the weight that students placed on the importance of the personal dimension of the relationship, citing such mentor qualities as support, empathy, encouragement and counselling as being most important to them.

The key feature of this literature overall then is the focus on the importance of the interpersonal relationship that exists between mentor and mentee.

Mentors and Facilitation of Learning

The purpose of mentoring is to enhance the professional development of the mentee and the literature reveals the multi-dimensional and nuanced nature of this process. A considerable body of knowledge has amassed regarding nursing students' views of clinical learning and mentorship (Earnshaw, 1995, Cahill, 1996, Spouse, 1998a, 2000, 2001a, Andrews and Wallis, 1999, Watson, 1999, Gray and Smith, 2000, Chow and Suen, 2001, Neary, 2000a, Pearcey and Elliot, 2004, van Eps et al., 2006). This provides us with an insight into the experiences of students and their views of what the mentoring role should consist. It has much to contribute to our understanding of the ways in which mentors facilitate learning and the aspects of the role that students have found beneficial to their learning.

It seems that there is a 'settling in' period (Earnshaw, 1995) in which mentor and mentee assess each other, and then, as the relationship becomes more relaxed, trust is developed. Despite the confusion that surrounded the role, as discussed in a previous section, students themselves articulated what it was they felt they needed to support their learning. Students required mentors to be assessors,

facilitators, role models and to help with planning and provide them with support in clinical settings (Watson, 1999). Assisting, guiding and befriending were aspects of the role identified as being most crucial to students in Chow and Suen's (2001) study. Generally, this literature reveals that appropriate contact and sufficient time spent with mentors is appreciated by students.

There are many challenges that exist in the facilitation of learning in the workplace. These difficulties are an enduring feature of the literature across the decades, evident despite the many changes to pre-registration nurse education during the period. The most frequently cited problems are lack of time and poor planning. In Cahill's (1996) study, students identified lack of contact time with mentors as a major source of dissatisfaction. Students attributed this to a combination of mentors' lack of interest in them and poorly organised shift patterns. This being a small, non-representative study, conducted many years ago it might be dismissed as now being irrelevant to contemporary experience. However, a number of subsequent studies corroborate the findings. For example, lack of mentor contact was a feature of Watson's (1999) study, where all students had an interrupted period of mentoring. Watson's study is also based upon a small sample size (n=35) and is limited in scope in that it considered students on one module during the common foundation programme. It is notable that lack of mentor contact was reported by all students in Watson's study. Unfortunately, the author does not give a clear account of the degree to which lack of contact applied to each student. For some students, contact time with their mentor was certainly minimal, or even non-existent, as a result of mentors being moved to different areas, having conflicting shift patterns, annual leave or sickness absence.

Lack of mentor contact time is an enduring theme within the literature, the impact of which has been shown to have a negative effect upon student learning (Lloyd Jones et al., 2001, Gray and Smith, 1999). In the absence of the named mentor, it seems that other staff attempt to cover activities of their missing colleagues. However, the most significant finding of Lloyd Jones et al. (2001) was that students whose mentors were absent spent considerably less time than other students working with a registered nurse. The amount of time that such students spent on education-related activities was reduced. Their findings should be treated with some caution for a number of reasons. Data were gathered by means of activity diaries for a 'snapshot' of one week, over such a short timescale activity may not have been typical. 270 students and their named mentors were approached to participate in the study. The overall student response rate was 46.3% (n=125); the overall mentor response rate was 45% (n=117), only 81 student-mentor pairs completed the diary for the same week. These are relatively low response rates; furthermore, the authors conjecture that staff and students who did not complete the diary were particularly busy but this was stated explicitly only in some cases. From this they make an assumption that mentor-student contact may have been lower amongst non-respondents than amongst respondents and therefore their findings are likely to be an overestimate of the time spent by staff mentoring students. This is a conclusion that is not based upon sound evidence.

Students are largely dependent upon their mentors to provide them with opportunities to engage in professional activities (Spouse, 1998a, 1998b). Without such support it is understandable that students would not gain access to appropriate learning activities to contribute to their learning and development.

Spouse (1998b) argues that the mentor is the 'sponsor' to the placement and without effective sponsorship students find it difficult to participate in the clinical setting or to learn. In a similar way, Gray and Smith (1999) see the mentor as the 'linchpin' of the students' experience in clinical settings in relation to their professional socialisation. They reported that, left unsupervised, students were more likely to be delegated tasks that were more appropriate for a health care support worker.

The literature has less to contribute in helping to discern how mentors see their role in promoting students' professional development. Jinks (2007) points out that mentor specific research is an under addressed area but one that is becoming increasingly important. What emerges from the literature that does exist confirms that mentoring is a skilled and complex activity. Mentors, in common with their mentees, acknowledge the significance of the interpersonal aspects of the role. (Atkins and Williams, 1995, Andrews and Chilton, 2000, Watson, 1999, Watson, 2000, Spouse, 2001b, Pulsford et al., 2002, Myall et al., 2008).

Mentors have raised issues such as the importance of being prepared for the role, the time and energy consuming nature of mentoring, the complexity inherent in the role and the high level of commitment required to undertake it successfully. They have also recognised the potential of mentoring to further their own personal and professional development (Atkins and Williams, 1995). Mentors in Atkins and Williams (1995) study emphasised the importance of 'supporting' students and identified a variety of ways in which they did this. They also believed that their presence reduced the anxiety of students, particularly for those students new to clinical practice. According to their findings mentors empathised with students,

encouraged them and talked them through difficult situations in clinical practice. They spoke of concern for the mentees as individuals, highlighting the many stressors that impact upon students. For instance, how extraneous issues such as debt and living away from home for the first time can impact upon students' professional lives. This was a small-scale study (n=12) published some 17 years ago in a single health authority area in England. The participant mentors were nurses, midwives or health visitors, though the authors do not attribute roles in any of the quotations used to illustrate their findings or identify the numbers of midwives or health visitors supporting nursing students. The implications of this, if any, are not considered by the authors. The participants constitute a small purposive sample and the authors do not make any claims for generalizability of their findings. It is important to remember that at this time mentor preparation tended to be rather 'ad hoc'. The authors state that the participant mentors in this study were selected, prepared and supported in their roles by lecturer practitioners. Detail of selection criteria, type of preparation or how support was given is not provided. Furthermore, this study was conducted at a time when the participant mentors were new to their role. In evaluating what this research has to contribute to current understanding of mentor-mentee relationships it is important to consider that the student profile of those entering the profession may have changed since this research was conducted. For instance, fewer students enter the profession directly from school now; more mature individuals may be more resilient to the pressures of student life. That said, Atkins and Williams (1995) research does give an indication of the heavy emotional toll that is exacted upon mentors. In my Health Board area, students undertake clinical placements in a remote setting removed from usual networks of support. This can be challenging

for students as they adjust to new living and working conditions, mentors may have to deal with more student issues as a consequence.

Assessment and Accountability

The literature revealed that for mentors the area that seemed to provoke most concern and anxiety related to assessment of students. Assessment of clinical practice has been recognised as problematic for some time (Clifford 1994, Neary 2000a, Watson et al., 2002, Dolan, 2003). Clifford (1994) in an early paper bemoaned the distancing of nurse teachers from the assessment process located in the practice setting. Clifford was concerned that clinical practitioners might not be as able as nurse teachers in making assessment decisions. Much has changed in nurse education since Clifford's contribution to the debate and the suggestion that nurse lecturers resume responsibility for student assessment seems unfeasible even if it could be shown to be desirable. Today it is mentors, prepared for their role, who carry out continuous assessment of their mentees. However, achieving fair and reliable assessment of students' clinical performance is still at issue. Watson et al. (2002), having conducted a systematic review of the literature during the period 1980-2000, raise the problem of subjectivity relating to assessment of competence in nursing. In their view competence is a poorly defined term and assessment of competence is problematic due to lack of rigour in the instruments and methods used for assessment. They point out the likelihood of bias, in either direction, where one person, such as a mentor, is making an assessment decision. The mentor is likely to be assessing a student over a significant length of time during which a socialization process takes place that may bias assessment. This was a key finding of a study by Webb and Shakespeare

(2008) who conclude that judgements of student competence are made on a relatively subjective basis, with the personal relationship between mentor and mentee a fundamental element of how decisions were made. Their findings were based upon a small, exploratory study with participants in the categories of experienced mentors (supervised three or more students, n=10), inexperienced mentors (still training for the role or had only previously had one or two mentees, n=5) and third year students (experience of mentorship, n=9). The authors had hoped to recruit equal numbers to the study in each category but note the difficulties in achieving their original aim due to securing appointments with busy clinicians. Furthermore, for the same reason, the researchers adopted a very flexible approach to data gathering. Interviews were employed to collect data but they took a variety of forms, four of the nine students being interviewed as a group, the others being interviewed in individual face to face interviews. Five mentors from one hospital site had telephone interviews, all other mentor interviews were face to face. The limitations of the study lie in the small number of participants and that it was a convenience sample. However, the authors argue that dependability and transferability are enhanced in that 2 researchers, from different professions, nursing and sociology, carried out the interviews, lessening the likelihood of researcher bias. Also, varying interview types and the fact that data were drawn from different research sites enhance the trustworthiness of the research. On the other hand, four of the students were interviewed as a group. It is possible that the views of one strident student might have swayed the views of the others and thus skewed results. The authors claim that this is unlikely as their findings are a replication of other studies. Their findings revealed that students must invest in a considerable degree of emotional labour in order to convince their

mentor that they are a 'good student' in terms of attitudes as well as clinical competence.

These findings indicate the complexity involved in student assessment. There is also recognition that assessment of one individual by another can never be viewed in completely objective terms, particularly in the clinical context where there are so many variables to be considered. The literature acknowledges how problematic assessment of student performance can be but alternatives seem to offer no better solutions. Clifford's (1994) early suggestion that assessment might be conducted by an 'external' person is fraught with difficulty. Such a person, possibly a member of the university practice education team, would be making decisions on competence based on a very short observation. Students might not perform at their best in such circumstances, for instance due to nervousness. Assessment decisions would be made on the basis of a 'snapshot' that may not reflect overall performance. Furthermore, given the constrained financial situation in which most universities operate it would seem unrealistic to implement such arrangements, given the complexity involved in organisation and consequent pressures that would result on nurse lecturers' workloads.

Neary (2000a) reports the findings of two studies carried out over a period of 6 years (1991-1996), aiming to establish what occurs in relation to assessment of competence of nursing students. The data from the two studies are merged in Neary's account to provide a focused picture of how both students and participants perceived their roles in assessment and support systems in place at the time of the studies. Neary drew data from a large number of participants, 200 practitioners and 300 students over 3 colleges of nursing in the first study, in the

second data were drawn from interviews with policy makers, teachers and nurses (n=360), this formed the basis for a questionnaire administered widely (n=1332). Reflective diaries were also completed by 138 students and 133 practitioners. This research was carried out during a period of time when there was intense debate surrounding the remit of the role, whether or not assessment should be included within it. This aspect of debate is currently resolved with assessment of students as a key component of the role (NMC, 2008a). Nonetheless, Neary's study provides interesting insights that still have resonance in contemporary practice regarding the process of assessment. Neary (2000a) draws attention to a variety of problems associated with assessment; these include 'personality factors', the constraints of time and disparity that existed between objectives set in college compared with the realities of placement. In Neary's study one student said that assessors were afraid to give adverse comments because it could cause problems with college staff and that 'it creates too much paperwork if a student is reported because of failing to achieve' (Neary, 2000a, p. 472). The issue of mentors being ill equipped to make decisions about a student's 'fitness to practise' has been a major concern. Indeed, it was concerns about the quality of support that students received and the nature of assessment in clinical practice led the NMC to embark upon a consultation exercise in 2004 that led to the publication of the 'Standards to support learning and assessment in practice' (NMC, 2006). The consultation proposals were informed by research conducted by Duffy (2003) relating to mentors 'failing to fail' students who perform poorly in practice. Duffy (2003) conducted a qualitative study of factors that influence the decisions regarding assessment of competence in practice. Mentors commented upon the time involved in supporting a failing student and the emotional impact of failing a student, giving resonance to research discussed in the previous section. Mentors

used such words as 'horrendous', 'traumatic' and 'draining' to describe their experiences and spoke of the sadness and sometimes anger engendered by the process (Duffy, 2003, pp. 34-38). Their sadness derived from the personal impact that their decisions had upon students and the feeling that they had let down their students. Anger resulted when they had to deal with students whose poor performance should have been identified much earlier in the programme.

The NMC (2008a) expect mentors to provide constructive feedback to students and assist them in identifying future learning needs and actions. 'Sign off' mentors are expected to confirm whether or not students have met the NMC standards of proficiency in practice and are safe and capable of effective practice. However, the literature reveals that assessment of capability remains an area of difficulty for mentors. A survey of nearly 2,000 nurse mentors by the Nursing Times (2010) found that 37% had passed students whose competencies or attitude concerned them, or whom they felt should fail. 69% struggled with or did not manage the paperwork relating to students, 17% had their decisions to fail poorly performing students overturned by a university. This seems to demonstrate that assessment of students is an area of the mentor role that remains problematic. The literature indicates the multi-faceted nature of the problem. Mentors know that the process of failing a student on clinical placement is time-consuming and takes a heavy emotional toll on all involved. A percentage of 'fail' decisions are overturned by universities, either because the decision making process is not transparent or mentors have not adhered to correct procedures within timescales. Duffy (2003) noted mentors sometimes 'left it too late' before notifying a student that there was a problem. This made a successful appeal against the decision more likely as the student could argue that they were not given enough time or support to correct the

problem. Mentors may feel inadequately prepared to make decisions that can have such a devastating impact upon students' careers and lives and may not feel able to cope with students who may become upset, angry or disagree with their assessment decisions (Carr et al., 2010). The literature reveals assessment of students as a particularly challenging aspect of the mentor role.

Mentor preparation and support mentors say they need

In this section I review what the literature says about mentor preparation. This is an important element within the literature, helping to shed light on how mentors have been prepared for their role, contributing to my understanding of the experience of potential mentor recruits to my study. I also consider what the literature can add to an understanding of the on-going support that mentors say they need to help them carry out the role effectively.

In 2006 the NMC stipulated that nurses who intend to take on the role of mentor must have successfully completed an approved NMC mentor preparation programme, or an accredited programme (NMC, 2006). In response, there is now a core curricular framework for the preparation of mentors across Scotland (NES, 2007), the aim being to refocus current mentor programmes on the principles supporting learning. However, prior to the implementation of the NMC (2006) standards there seems to have been a lack of consistency across the UK in the ways in which mentors were prepared for their role. For example, in England a number of programmes were utilised to prepare mentors, such as the ENB 998 Teaching and Assessing course and the City and Guilds 730 course. In Scotland a range of approaches was adopted by HEIs for example, Duffy et al. (2000)

describe an approach to mentor preparation that included either half or full study day and 'drop in' sessions for practitioners on-site at their workplace. The authors do not provide any detail of learning outcomes for such sessions.

There has long been acknowledgement of the need for robust preparation and updating for those who undertake the mentor role (Atkins and Williams, 1995). The main benefit of undertaking a mentor preparation programme seems to be in the confidence this engenders, helping mentors to feel more at ease with the role, rather than any direct application to practice of what they had learned (Andrews and Chilton, 2000). Andrews and Chilton's (2000) study revealed that registered nurses with a teaching and assessing qualification rated themselves as more effective and supportive than those without. The authors do not seem to have considered other variables, such as length of time in the role of registered nurse, which may have impacted upon confidence levels. Furthermore, the possession of such a qualification was not reflected in the way in which students rated mentors.

The literature provides evidence that the rather inconsistent approach to mentor preparation and variable quality of on-going support resulted in mentors feeling ill-prepared for their role (Jinks and Williams, 1994, Wilson-Barnett et al., 1995, Lloyd Jones, et al., 2001). Confusion surrounding the remit of the role and perceived deficits of mentors in undertaking it, led some to call for the introduction of additional support roles. For example, Andrews and Roberts (2003) report on the introduction of a 'clinical guide', a senior member of clinical staff allocated to students for the duration of their programme. Such guides did not work directly with students, or assess them; rather their role was to help students make sense of clinical placement, helping them to achieve deeper learning in and through

clinical practice. As experts, Andrews and Roberts (2003) argued that guides were able to deal more ably than junior mentors with increased academic emphasis in nursing curricula. It is interesting that the authors saw the solution to mentor deficits in providing another layer of support rather than addressing the perceived short comings of the current mentors. This was not a view that was widely accepted. In 2004 the NMC launched a consultation on how mentorship could be supported and made more robust, leading to the development of the NMC (2006) standards to support learning and assessment in practice. The focus is now very firmly on the mentor as the key support for nursing students. However, Andrews et al. (2010) draw attention to the challenges for both practitioners and the organisations in which they work to implement and sustain the nursing and midwifery standards for mentoring.

In terms of on-going support, the literature reveals much dissatisfaction amongst mentors in this respect. Duffy et al. (2000) concluded that much was still required to provide mentors with the support they felt they needed but specifics remain unclear in their report. Lack of time is a key aspect of the dissatisfaction that mentors identify both in terms of their ability to attend updating sessions and to devote to carrying out the role effectively. Heavy clinical commitments impact upon mentors' ability to attend study days (Duffy et al., 2000), thus denying them potential means of support. Pressures of time led mentors to undertake aspects of the mentor role in their own 'off duty' periods (Pulsford et al., 2002). As well as identifying lack of time, mentors also identified management support and partnership working with HEIs as areas that required more support. Pulsford et al. (2002) gathered data by means of a questionnaire distributed to 400 mentors. Their findings should be treated with caution as their response rate of less than

50% (n=198) is considered 'not scientifically acceptable' by Mangione (1995, p. 61). The methodology they employed must also shed doubt on their findings, as some of the mentors surveyed had very little contact with students, bringing the value of their contribution into question.

The issue of lack of support from academic staff is reported elsewhere in the literature (Cahill, 1997, Aston et al., 2000). The reason for this seems to be that academic staff based in universities had many competing demands upon their time, reducing the time to meet support needs of mentors in clinical practice. Phillips et al. (1996a, 1996b) found that the support that was provided was not always acknowledged by mentors but that academic staff described their roles as linking and liaising with practice rather than providing 'active' support to mentors. The rather nebulous terminology used makes it difficult to understand the support that academic staff were able to provide. Watson's study (2000) lends weight to the view that both HEIs and NHS trusts provide inadequate support to their mentors. He called for lecturers to be more available to mentors and for NHS trusts to invest more in mentoring to provide better mentor preparation and more time to undertake staff development in the facilitation of learning. In 2004 the Practice Education Facilitator (PEF) role was established in Scotland, whose purpose was to ensure that the student experience is of the highest quality, primarily through the support of mentors. The role was introduced in an effort to improve student experience, acknowledging that there can be a number of challenges in providing a positive learning environment in busy clinical settings. Evaluation of such roles seems to demonstrate that they are a valuable resource in achieving high quality support for mentors (Carlisle et al., 2009).

Summary of the literature relating to mentoring in nursing

Learning takes place in practice settings for at least 50 per cent of pre-registration nursing programmes. The existing literature reveals the vital role that mentors play in the education and development of the next generation of registered nurses. It also indicates the complex and demanding nature of the role as mentors must supervise unregistered staff in delivering care and provide support for their mentees. The early literature concentrated on the role and remit of the mentor whilst later contributions focused on the value and effectiveness of the mentor role. The literature charts the evolution of the role of mentor, culminating in the introduction of new standards for nursing and midwifery practice education (NMC, 2006). When the role is undertaken effectively it can be seen as the lynchpin in providing access to good quality learning experiences for students in practice. The NMC (2006) standards provided a clear statement of what the expectations of the role were to be, mentors were to facilitate student learning in practice and to assess student competence. 'Sign off' mentors were introduced, experienced practitioners who would make judgements about a students' suitability to be admitted to the professional register. These mentors have a professional responsibility to protect the public, acting as gatekeepers to the profession. Issues surrounding student assessment are prominent in the literature and identified by mentors, students and lecturers as an area of concern. Many factors are identified in the literature as impacting negatively on mentors' ability to support student learning. Chief amongst these is lack of time which is identified as a key impediment to effective clinical learning. Mentors have also identified lack of support from university staff and NHS managers as being detrimental to the way in which they are able to carry out the role. The literature reveals the extent to which

interpersonal relationships are considered to be the key determinant of a successful clinical placement.

Conclusion

Reviewing the existing literature helped me to gain a deeper understanding of the subject. It helped to set my own research in context from both a policy and historical perspective. Mentors' experiences and perspectives seem a relatively under researched area when compared with the body of knowledge that has accrued regarding student views. This is particularly so for mentors located in remote settings. I therefore felt it appropriate to develop research questions that would provide insights in this respect. I devised a broad overarching research question to explore the role of the mentor, **'What role do mentors play in facilitating learning in practice?'** My analysis of the literature identified three main areas of mentor experience relating to how they view their role, how they pass on their skills and knowledge and the factors that impact upon mentors' abilities to carry out their role effectively. My sub-questions were more focused to address these areas identified in the literature.

- **How do mentors see their role in promoting students' professional development on clinical placement?** This sub-question was derived from the literature relating to the value and effectiveness of the role of the mentor and how mentors establish effective working relationships.

- **How do they support students across the 4 domains identified by the NMC (2004) (Professional and ethical practice, care delivery, care**

management and personal development)? This sub-question derived from the literature relating to mentors and the facilitation of learning.

- **What factors influence mentors' ability to promote student learning?** This sub-question sought to explore areas that mentors identify as having either a positive or negative impact upon their ability to promote student learning. It integrates the literature relating to the support that mentors say they need to carry out the role and includes the literature relating to assessment, in which mentors seem to indicate they require more support.

This research was undertaken to gain further understanding of some of the issues discussed in the literature review. I sought to explore the perceptions of mentors, seeking to gain insights into their personal experiences of supporting students in a remote setting. In the following Chapter I provide an account of how I undertook the research.

3. Research Design

In this chapter I discuss the research design of this study. It deals with the underpinning methodology and the methods used to collect and then analyse the data. My literature review revealed the complexity of the mentoring process and a number of key issues for potential exploration regarding the mentor role. These related to mentor motivation in undertaking the role, how mentors transmit knowledge to mentees and the circumstances in which learning takes place in clinical settings. My research questions arose from this analysis of the literature as I sought to contribute to understanding of the experiences of mentors supporting pre-registration nursing students in the context of a remote and rural setting. This led me to pose the question, **'What role do mentors play in facilitating learning in practice?'** I devised sub-questions to sharpen focus on my main research question and specifically address the areas arising from the literature regarding motivation, day to day activity and what helped or hindered mentors to carrying out their role effectively,

- How do mentors see their role in promoting students' professional development on clinical placement?
- How do they support students across the 4 domains identified by the NMC (2004) (Professional and ethical practice, care delivery, care management and personal development)?
- What factors influence mentors' ability to promote student learning?

To answer these research questions I developed a research design directed by this purpose, to increase understanding of the experiences of mentors. The research takes an interpretative approach guided by the principles of grounded theory. As a novice researcher, my research design was not 'cut and dried' at the start of the project, rather it evolved slowly and 'painfully' as I carefully considered my research goals and how I could reasonably achieve them. As I struggled to decide on the approach that would best provide me with the information I sought I came to realise that the research process necessarily involves compromises and 'trade-offs'. This chapter presents a justification for the choices I made in my efforts to attain knowledge that was trustworthy, constrained as I was by limited resources and by being in full time employment as I pursued my EdD studies.

The first two subsections deal with why I adopted an interpretative approach using grounded theory methodology. I then describe how I negotiated access and recruited participants to the study, then present the participant mentors. This is followed by a reflection upon ethical considerations that influenced my research, and the implications of my 'insider' status, including a reflexive account acknowledging my role and influence on the research. I describe how data were gathered by means of interviews and diaries and then discuss rigour and trustworthiness, I conclude the chapter with a detailed account of how the data were analysed.

An interpretative approach

In deciding upon my research approach I considered a number of research traditions. To guide my choice I kept the purpose of my research to the forefront

of my mind at all times. My task was to select an approach most closely aligned to my research questions to increase understanding of the experiences of mentors. The literature reveals that there are different philosophical positions taken on the nature of reality and on the researcher's relationship with research participants. Schutz, cited in Bryman (2008, p.16) captures this difference when he states that 'The world of nature as explored by the natural sciences does not 'mean' anything to molecules, atoms and electrons'. In contrast, social reality has a specific meaning and relevance to those individuals, such as mentors, being studied. Bryman (2008) argues that an epistemology is required that can reflect and capitalise on this difference. Bearing this in mind, I considered both qualitative and quantitative research traditions, considering carefully the underpinning philosophical differences between them. These approaches are often presented in starkly divergent terms in the literature. Silverman (2004, p.1) speaks of dwelling in 'armed camps' and of 'fighting internal battles'. Morse and Field (1996, p.2) speak of the 'rift' that exists between proponents of the two paradigms. More recently Burgess et al. (2006) have argued that such 'warfare' is a waste of time. In making my research choices I felt it important to weigh the relative merits of each approach as I now describe.

I decided that a qualitative approach seemed to be most appropriate for my needs because it lies within an interpretivist tradition. In this view it is argued that there are no 'absolutes' and that phenomena can be studied and interpreted by humans in different ways (Burgess, 2006). Bell (2010, p.6) asserts that such an approach is appropriate for those who 'doubt whether social 'facts' exist and question whether a 'scientific' approach can be used when dealing with human beings'. A qualitative approach tends to focus on natural settings rather than controlled

laboratory settings. Polgar and Thomas (2008, p. 84) define it as, 'disciplined enquiry examining the personal meanings of individuals' experiences and actions in the context of their social environments', and this seemed to encapsulate the aim of my project. The interpretivist perspective lies within a naturalist, or constructivist, paradigm. In this view, 'reality' is a rather elusive concept, not a fixed entity but a construction of those participating in the research. This naturalistic view stands in contrast to that of the 'scientific' method with its assumption of a 'detached' researcher (Tarling and Crofts, 2002). Quantitative approaches lie within a positivist tradition, which asserts that an objective reality exists and is possible to measure by utilising tools and principles borrowed from the scientific world. Within this paradigm there is less room for doubt (Burgess et al., 2006). I decided that a positivist approach was inappropriate as I sought to gain an understanding of mentors' subjective interpretation of experiences. Positivist approaches can disregard data considered too subjective and I felt that this would result in important aspects of mentor experience being rejected. Within a positivist tradition the researcher would tend to use research tools such as structured questionnaires and complex sampling techniques. To provide answers to my research questions a qualitative approach, utilising such tools as semi-structured interviews, would allow me to gather data from mentors where I could take account of how social and other factors influenced their experiences and behaviour. I could thus value respondents' views in helping me to understand the world in which they live, accessing their 'personal, intimate and private world' (Parahoo, 2006, p. 65).

As I now reflect back to the start of my project I feel embarrassed at my rather naive attitude. I set out with the aim of recording 'the truth' and identifying 'reality',

eliciting insights never before realised! As I thought more deeply about my research topic and read the literature I saw that even by strict adherence to data collection methods that eliminated or minimized the scope for personal judgement and subjective bias I still was not guaranteed to gain what Eisner (1992) describes as 'ontological objectivity'. Eisner argues that perception and understanding are part of a framework that allows us to perceive and understand some things but not others and this framework plays a role in actually constituting what we see and understand. He states that there is an unwillingness to relinquish the notion of objectivity because this would leave us feeling cast adrift, without bearings (Eisner, 1992). His views are hotly debated in academic circles. Phillips (1989) argues that 'extreme' relativism leaves us in an untenable position and that abandoning objectivity would mean accepting that any view is as good as any other. Having considered these different perspectives I concluded that working within a naturalistic paradigm was an appropriate way in which to move forward with my research. Within such a paradigm I could acknowledge that 'reality' is not a fixed entity but a much more elusive concept, mentally constructed by those involved in the research. In trying to gain insight into mentors' experiences and perspectives I was relying upon their subjective views and my findings were a product of the interaction between us. Taking such a stance, accepting that all knowledge is fallible, still allows for a disciplined enquiry. I have tried to demonstrate trustworthiness in the way that I have collected and analysed my data, demonstrating that the processes I have used have been undertaken in a rigorous and systematic manner.

Grounded theory

Having decided to conduct my study within a naturalistic paradigm I then sought an approach that would best help me to achieve my research aims and objectives. I perceived there to be advantages in adopting a grounded theory approach and here I present my rationale for doing so. Grounded theory is an inductive approach to research and as such is in keeping with the research paradigm I have chosen to adopt. It was developed by sociologists Glaser and Strauss (1967), described in their influential book, 'The Discovery of Grounded Theory'. My research questions aimed to increase understanding of the experiences of a small group of mentors within an island Health Board setting, this having been revealed in my review of the literature to be an under researched area. I considered grounded theory to be an appropriate approach as it is often used when little is known about a topic (Holloway and Todres, 2006), and my literature review revealed little regarding mentor experiences in remote settings. I was aware that my sample size, being so small, might preclude attempts to build theory from my analysis but it would provide information about how participant mentors view their practice. Crooks (2001, p. 25) states that 'grounded theory gives us a picture of what people do, what their prime concerns are, and how they deal with these concerns'. As it is drawn from the data, a grounded theory approach can offer insights into the way that individuals make sense of their world, helping me to gain understanding of the mentors' world from their perspective. Holloway and Todres (2006, p.193) suggest that the most important research questions in grounded theory are process, behaviour and meaning questions such as 'how do people act and interact in this situation?' and 'what is the meaning of people's experience?' These reflect my own research questions reinforcing the appropriateness of a grounded theory approach. Furthermore, it could be argued that an emergent

theory derived from the data is more likely to resemble 'reality' than one derived from piecing together different concepts. Taking all of the above into consideration, I concluded that a grounded theory approach offered an appropriate methodology with which to explore mentors' experiences of mentorship.

In reaching my decision I did consider other approaches commonly used within the interpretivist tradition. For example, an ethnographic approach initially seemed to offer prospects of gaining insights into the mentors' world. Ethnography is an approach relying on the collection of data in the natural environment; the ethnographer is interested in how the individual being studied is influenced by the culture in which they live. In this approach, human behaviour can only be understood if studied in the setting in which it occurs (Parahoo, 2006). Ethnography is a research method in which the researcher is immersed in a social setting for an extended period of time, making regular observations of the behaviour of members in that setting (Bryman, 2008). Participant observation is a key element of this approach, interviews only being used to supplement data gathering on those issues not directly amenable to observation. I rejected an ethnographic approach for a number of reasons. I wanted to gain insights into the mentors' own experiences and felt that this might be better achieved in an approach grounded in the data mentors provided themselves. On pragmatic grounds, as a lone researcher with very limited resources, I felt that participant observation in clinical settings would be difficult to co-ordinate and carry out and was potentially intrusive to the work of busy clinicians.

However, grounded theory is not without its critics. Thomas and James (2006, p.768) challenge the 'lofty place' its methods have come to hold in social analysis.

Whilst acknowledging the major contribution Glaser and Strauss (1967) have made to legitimising qualitative enquiry they argue that creating 'theory' with strict procedures for doing so, might inhibit rather than liberate discovery. In their view, grounded theorists and other qualitative researchers are human listeners who then interpret the data on their experiences of being human. I also took account of the way in which grounded theory has evolved over the years since its inception. Glaser and Strauss (1967) started together developing grounded theory but subsequently they diverged from each other. Glaser's approach to grounded theory is termed 'traditional', whilst Strauss and Corbin's (1998) is described as 'new positivist'. I decided to adopt an approach adhering most closely to that of Strauss and Corbin (1998). I made this decision because as a novice researcher I felt more reassured by the detailed descriptions of how to carry out coding provided by Strauss and Corbin (1998).

On balance, I concluded that grounded theory as a methodology had much to offer in helping me to answer my research questions as outlined above. Additional reasons for using grounded theory included its flexibility, which is suited to a novice researcher such as me. It offers an entire approach to the conduct of field research and data analysis without being tied to a pre-determined theoretical framework. Grounded theory is very popular in investigating nursing phenomena (Schreiber and Stern, 2001) and appealed to me because my familiarity within the field can provide theoretical sensitivity to concepts and issues that are important for the developing theory (Holloway and Todres, 2006).

Tesch (1990) depicts 26 different types of qualitative research but argues that just because some research methods have been named this does not mean that they

must always be used in exactly the same way by every researcher. In the present study I have adhered to the principles of a grounded theory approach in conducting my research and in data analysis. The structure of the Open University EdD programme encouraged early identification of clear research questions arising from a comprehensive literature review. This seemed to contradict Strauss and Corbin (1998, p. 49) who argue that it is impossible to know prior to the investigation what the salient problems will be and that researchers should not be 'constrained' or 'stifled' by the literature. However, I felt it important to review the literature at an early stage in the study to enhance my knowledge and build my confidence and from this review was able to set a broad research question. Another issue that arose was that the collection of data was dependent upon the availability of busy clinicians. This impacted upon the chronology of when interviews could be held and when diaries were completed, so that diaries had not always been completed prior to second round interviews. Tesch (1990, p.71) says there is only one requirement of research, 'that you can persuade others that you have indeed made a credible discovery worth paying attention to'. Horton Merz, cited in Burgess et al. (2006), echoes this point stating that doing research is about developing one's own research voice or way of thinking that is not bound by tradition but instead by the meaningfulness of the study. I hope in this study to convince the reader of the merits of my research.

Data collection

In this section I provide a description of the methods used to collect the data. I discuss issues relating to access, present the participant mentors and give a rationale for my choice of interviews and diaries. I kept my research questions

uppermost in my mind as I considered research tools that would help me access the personal insights of mentors, in keeping with the naturalistic paradigm of my research. I first considered not 'which methodology?' but 'what do I need to know and why?' before considering how to gather information (Bell, 2010). Interviews and diaries seemed particularly appropriate in providing data that were congruent with my grounded theory approach, as they provided a means of gathering data directly from the mentors expressing their own personal views. Furthermore, they could be used in conjunction with one another, for example, using information gleaned from diaries to inform and focus subsequent, 'second round' interviews. Using two data gathering tools in this way might allow me to obtain different perspectives from participants on the same topic thus enhancing the trustworthiness of my data (Denzin, 1989). I also had more pragmatic issues to consider when making my choices. I needed to employ research methods that would not be onerous for busy clinicians; I also was subject to constraints of time. The research strategy that I adopted was a compromise between methods I hoped would provide me with appropriate data and the time and resources available to me. I decided to interview mentors who responded to an advertisement for volunteers. Data were collected by means of one to one interviews with participants. Further data were garnered by means of reflective accounts recorded in diaries, compiled when these same mentor participants next mentored a student. I then held 'second-round' interviews, the data from the 'first round' interviews and diaries bringing a sharper focus to these subsequent interviews. The data gathered by interview and the reflective accounts from diaries were analysed according to the principles of a grounded theory approach.

Recruiting to the study

I met with the Chief Executive of my Health Board and gained agreement for my project in principle, subject to NHS ethics committee approval. This was encouraging; I felt that I had achieved the support of a 'champion', someone who would be prepared to vouch for the value of me as a researcher and the project (Bryman, 2008). The Nurse Director was also supportive and gave her consent to mentors being interviewed whilst 'on duty', rather than during their own time. I realised that the key 'gatekeepers' were the senior charge nurses who were the direct line managers of mentors. I attended meetings with them and explained my research aims, objectives, and research methods. This met with a positive response. I was aware that people would be doing me a favour if they agreed to help and I wanted to be clear about what I was asking of them. I tried to be honest with regard to my estimates of mentors' time involvement in the project, stressed that it would not be onerous, involving 2 interviews of one hour or so during the total duration of the project, estimated at 3 years. I confirmed that I would employ flexibility in arranging meetings with mentors.

Participant mentors

There are 18 clinical placement areas across hospital and community settings, with approximately 100 mentors recorded on the locally held mentor register. They support a range of nursing students in the workplace; the majority undertaking NMC approved pre-registration nursing programmes of three or four year's duration. This research set out to explore the perceptions of these mentors.

I devised an advertisement (Appendix 3) seeking expressions of interest from mentors who might be willing to engage with the project. I distributed this widely

throughout my Health Board area electronically and in 'hard copy' to all clinical areas. It was also displayed on notice boards. I was keen to reach both new and experienced mentors from both hospital and community settings to access a range of views and experiences. With a pool of only 100 mentors, I did not want to set restrictive admission criteria and fail to achieve sufficient respondents. Therefore, the only criterion I set for admission to the study was current registration on the locally held mentor register. I received 10 expressions of interest. Each respondent was sent an information sheet (Appendix 4) providing more detail of my research. Having read this, all agreed to proceed. I allowed a minimum of two weeks between issuing information sheets and commencing the research so that potential participants did not feel pressured into proceeding. 10 mentors were recruited to the study. Prior to interviews taking place I asked participants to sign a consent form (Appendix 5). Later in the project, I provided a further information sheet to explain the use of diaries and gained consent for this also (Appendices 6 and 7). 8 diaries were completed in total. **Table 3.1** presents the mentors participating in the research. Pseudonyms have been used to protect mentor identity.

MENTOR	YEARS OF FORMAL MENTOR EXPERIENCE	CURRENT AREA OF PRACTICE	INTERVIEWS 1 & 2 DIARY (D)
Betty	11	Community	1
Chris	15	Community	1,2, D
Emma	21	Community	1,2, D
Fiona	4	Community	1,2, D
Gloria	4	Community (practice nursing)	1,2, D
Heather	6	Community	1,2, D
Alex	10	Acute (A&E)	1,2, D
Dora	15	Acute (Surgical ward)	1,2 D
Irene	4	Acute (Medical ward)	1,2, D
Jacqueline	I	Acute (out-patient department)	1,2

Table 3.1 Participant mentors

Ethical Considerations

I was conscious of the importance of conducting my research within an ethical framework. Dockrell (1988) points out that concern with ethical considerations in educational research has increased in recent years; previously the emphasis was on technical standards. To ensure that I was following best practice I adhered to the British Educational Research Association's Ethical Guidelines throughout. As this research was being conducted within the National Health Service, I was required to seek approval from the Regional Research Ethics Committee. I was keen to progress my application, aware that when dealing with ethics committees the approval process can be lengthy and there is the potential for delay (Bell, 2010).

My decision to use diaries as a research tool came following my initial submission to the research ethics committee, I was then required to submit a 'substantial amendment request' (Appendices 8, 9 and 10 provide examples of correspondence with the NHS research ethics committee). Permission to conduct the research was also sought and obtained from the Open University's Human Participants and Materials Ethics Committee and our partner University's School of Nursing and Midwifery Ethics Review Panel. I registered the project with the Open University's Data Protection Office. As a registered nurse I adhere to 'The Code: Standards of conduct, performance and ethics for nurses and midwives', (NMC, 2008b), I provided participant mentors with written information to remind them of my obligations to act should any information be revealed during the course of the research that might indicate poor practice in the workplace (Appendix 11). This situation did not arise but I felt it important to make my intentions explicit at this early stage.

I hoped that my information sheets and consent forms provided reassurances that the research would be conducted ethically. Anonymisation of the research participants occurred on recruitment to the study. Each mentor was allocated an identifying number, this was used to identify all the data provided by means interview and diary so that quotations could not be attributable. In writing this final report I have assigned pseudonyms, this is a personal preference, one I feel adds a human dimension to the narrative. I have removed references to the name of my Health Board area, conscious that the small numbers involved have the potential to compromise anonymity.

'Insider' research

Being an employee of the Health Board in which I was undertaking research conferred me with 'insider' status. 'Insider' researchers are variously defined (Hellawell, 2006) but are generally considered to have an intimate knowledge of the community they are researching due to previous and on-going association. It is usually assumed that this intimate knowledge is beneficial in that it offers insights that are difficult to achieve by an 'outsider'. As an 'insider' there were certainly practical advantages for me. For example, as I was 'on-site' travel was not a problem and I could contact mentors easily. Gaining initial access to mentors, once ethics committee approval had been granted, proved to be easy as I was able to tap into long established working relationships with the Chief Executive, Nurse Director and Senior Charge Nurses. I received a good response to my advertisement seeking participants to the study, which might not have been the case had I been completely unknown. I felt that I could establish a rapport with

mentors that might have taken many months to build as an 'outsider'. However, I saw my 'insider' status as a rather double edged sword in that there were also many pitfalls. On a personal level, I was conscious that as an 'insider' I would have to live with my mistakes if things went wrong with the research and that 'failure' would be a rather public affair. 'Outsider' research is where the researcher is not familiar with the setting being researched. This can be advantageous in that being a stranger, outside the social setting, it may be easier to 'retain perspective' and not take things for granted in the way that an 'insider' researcher might do. The regional research ethics committee had some concerns regarding my insider status and rejected my first application. The committee's view was that potential participants might feel obliged to take part due to my senior role in the organisation. The committee was reassured when I confirmed that I had no line management responsibilities for mentors and that participation was entirely voluntary. They were drawing attention to the 'power dynamics' that can be particularly problematic for insider researchers. There was a possibility that mentors saw participation in the research as a means of currying favour with me, of manipulating me in some way or of trying to impress me. I have no power to directly influence their careers and so thought this unlikely but awareness of such issues was important so that I could adopt strategies to minimise such possibilities. The committee thus highlighted one aspect of my relationship as an 'insider' with my research participants from an ethical perspective but there were many other dimensions to consider. I carefully weighed my relationship with my research participants throughout my research and have presented this in a summary format by adapting a framework devised by Le Gallais (2003) (See Appendix 12). Here I try to capture my understanding that 'insider' or 'outsider' research is not the stark dichotomy that might be assumed and that it is better

considered as a continuum (Le Gallais, 2003). I followed the advice of Hellawell (2006, p. 489), who asks that researchers consider the 'subtly varying shades of 'insiderism' and 'outsiderism''. He suggests that rather than there being one continuum, researchers should gauge their varying positions on a multiple series of parallel ones. This helped me to understand that my relationship with research participants was complex, multi-dimensional and in a state of flux and to consider how my 'insider' status impacted upon my research.

I tried to keep alert to the impact that my insider status might have as I conducted the research. For example, whilst interviewing I considered ways that being an 'insider' impacted upon my perspectives and interpretations and the way that respondents reacted to me (See Appendix 12). I devised strategies to mitigate negative aspects of my insider status, for instance, at interview stressing that there were no right or wrong answers to my questions. I have to accept that participants may not have been reassured by this but their often frank responses indicate that they were not inhibited.

Reflexivity

In qualitative research there is an acknowledgement that researchers influence and are influenced by the research they undertake. Reflexivity is one means of recognising this reciprocal relationship and making it explicit. This is in contrast to a positivist approach where in an effort to avoid the appearance of 'contaminating' data, researchers tend to 'write themselves out of the text' (Scott, 1997, p.133). Throughout my research I tried to adopt a reflexive approach to help account for my influence on the research process, as I hope to have illustrated with my

discussion throughout this chapter on the potential impact of being an 'insider'. I tried to be proactive in seeking out the subjectivity in my work, considering its implications as the research progressed, rather than just acknowledging retrospectively that it existed (Peshkin, 1998). As I was a lone researcher I did not have the different perspectives that colleagues might have offered and was aware that bias can be particularly insidious when only one person conducts a set of interviews (Bell, 2010).

Keeping a reflexive journal helped me to consider the part I played as a researcher and author in the construction of knowledge. The research methods I utilised, the decisions I made and my values and biases all had the potential to influence the research in a variety of ways. I used my journal to help explore the implications of such issues and to devise strategies to deal with them where possible. My research journal served a number of purposes charting both my personal as well as my research journey. For example, I wrestled with decisions regarding my research design, trying to balance advantages and disadvantages of approaches and seeking solutions to problems. For instance, I decided to audio record interviews, rejecting video recording as being too intrusive and inhibiting. Making a note in my journal of any issues that seemed of particular significance to mentors was a strategy to compensate for the lack of a record of body language. I also used a section of my journal in a more personal way, writing down my hopes, fears and doubts about the research process itself. For example, castigating myself for my lack of confidence and poor interview technique that I felt hampered me in gaining the information that I sought! Writing in this way was positive in that it provided much needed perspective and helped to keep me on track when I felt like giving up! I also tried to identify my own personal biases, for instance,

acknowledging that I admired mentors for the work they did and that this might lead me to present too 'rosy' a picture of their world and guarding against doing so. Bryman (2008) points out that 'Reflexivity' can encompass a variety of sub-meanings, including taking account of the researcher's relationship with those studied as well as methodological self-consciousness and self-reflection. My reflexive journal was used for all of these purposes and in this way was a resource in itself contributing to my research.

Research Instruments

In this section I discuss my use of interviews and diaries as data gathering tools. In making my choice of research instruments I considered those that were appropriate to my research approach. Interviews and diaries seemed congruent with a grounded theory approach, in giving access to the perspectives that mentors brought to their role.

Data collection by means of interviews began in March 2008 and continued until July 2008. Unfortunately, a number of personal issues arose at this time necessitating a suspension of my studies. Interviews resumed, with the same participants, in June 2009 and all data collection was completed by August 2010. I tried to arrange interviews allowing for a minimum of a two week interval between each but this depended upon the availability of participants who travelled from outer islands to meet with me, and I wanted to be flexible to accommodate them. This time span between interviews was to allow for 'constant comparative analysis'. This is a key feature of grounded theory, in which data analysis helps to bring sharper focus to subsequent interviews, as I discuss in more detail later in

this chapter. In a similar way I hoped to collect data from diaries so that this could inform subsequent data gathering by means of interviews. However, the chronology of when diaries were completed was very dependent upon when students were allocated to clinical placements and whether participant mentors were allocated to mentor them, as presented in **Table 3.2.**

Date	'First Round' Interview	Diary when next mentoring a student	'Second Round' Interview
2008			
March	Alex		
June	Betty		
July	Chris Dora		
November		Chris (Nov 08-Jan 09) (Pilot for EdD Year One Report)	
December			
2009			
January			
June	Emma		
July	Fiona		
August	Gloria		
September	Heather Irene		
October	Jacqueline		
2010			
January		Alex /Emma/ Fiona/Gloria/Irene (Jan 10-March10)	
February			
March			
April			Irene
May		Heather*/Dora (May-Aug 10) *completed diary not available prior to interview	Chris Alex Fiona Heather*
June			Gloria Jacqueline
July			Emma
August			Dora

Table 3.2 Data gathering tools and chronology

Interviews

I decided to conduct one to one interviews with mentors from both hospital and community settings. I chose interviewing as the primary source of data collection as it offered an approach that was adaptable (Bell, 2010). This meant that I could adopt an interview style providing respondents with as much flexibility as possible to discuss issues that were important to them. In subsequent, 'second round' interviews I could focus on matters of significance that emerged from the data, in keeping with my grounded theory approach. Miller and Glassner (2004) state that the interview method may provide access to the meanings people attribute to their experiences and social worlds, helping me to achieve my research aims by gaining insights into the perceptions of mentors. Interviews offered the chance to probe mentor experiences in detail and gain an understanding of workplace learning through their eyes, providing, I hoped, rich information. I explained this approach in my pre-interview briefing and reiterated the written information distributed at the start of the study (Appendix 4).

My aim was to balance retaining control of the interview, by keeping mentors focused on the topic of mentorship, with adopting an 'informant interview' style (Powney and Watts, 1987). Powney and Watts avoid the myriad terms used to describe and categorise interviews, for instance, structured, semi-structured, unstructured, formal, in-depth and so on. They identify only two main styles described as 'respondent' or 'informant interviews', determined by where the locus of control is held. I tried to engage with mentors as informants and in such a way as to encourage them to collaborate with me in expressing their interests and concerns. I did this by having a broad topic list of areas to discuss in my 'first round' interviews but I used this as a prompt to stimulate discussion rather than as

a line of questioning to which I rigidly adhered. I tried to devise questions in reaction to the responses of the interviewees as a means to open up avenues of conversation. In this way I was able to probe responses and give latitude to what was discussed. This is important as in a grounded theory approach the field of enquiry derives from the participant's perspective (Glaser and Strauss, 1967). In 'second round' interviews I was more focused as a result of my on-going data analysis. In grounded theory, data gathering occurs until no new data emerges. Due to my small number of volunteers and limited capacity to generate large volumes of data, I was aware that I may not achieve 'saturation' (Strauss and Corbin, 1998, p.136). This would have implications for my research in a more 'tentative' presentation of assertions arising from my findings.

Venue

I carefully considered when and where to hold the interviews. I sought a relaxed, informal setting, away from busy, clinical areas. Bryman (2008) advises that interviews take place in a quiet place and one that is private, so that interviewees are not concerned about being overheard. I hoped such a venue might help to distance my role as 'researcher' from that of my position as 'Practice Educator'. I offered coffee and biscuits at the start of interviews in an effort to make the interview as non-threatening as possible so that mentors could relax and speak freely. I had known these mentors in a variety of capacities over many years, as I have held a number of roles within my Health Board area prior to my current post, including those of senior midwife and senior nurse. I hoped to build on an already established rapport but at the same time was cognisant of the disadvantages that can accompany 'insider' status, as I have discussed above.

Recording Interviews

Interviews were recorded, having obtained both verbal and written consent from interviewees (Appendix 5). As soon as interviews were concluded I labelled the tape, preserving anonymity of the mentors. All tapes were stored securely, in line with assurances provided to the ethics committee. I transcribed the tapes verbatim as soon as possible following interviews, in all cases within one week of the interview taking place. Interviews on average lasted for 1 hour and took approximately 10 hours to transcribe. I was concerned that audio recording might make the mentors feel awkward and reduce spontaneity of responses. This proved not to be the case and after a short period the interviewees seemed hardly to notice the microphone and recorder.

Interview style

Once interviews had been conducted and transcribed, I revisited the transcripts many times to analyse the mentors' responses but also to scrutinise my own role in the interview process. I tried to demonstrate the characteristics of 'good interviewers' as described by Morse and Field (1996, p.77) by adopting a passive role and not leading the interviewees. However, I was conscious of a dilemma. I was attempting to follow Morse and Field's (1996) advice by being an 'inconspicuous' researcher at the same time as trying to encourage the mentor in conversation. This was a difficult balance to achieve; I was full of angst, trying to 'pitch' the interview appropriately. For instance, in an effort to stimulate conversation I posed potentially leading questions such as, 'If I were to say that mentoring is demanding, how would you respond?' There were times in which I urged responses with a 'Yes, I know what you mean', or 'mms' and 'that's very interesting'. My body language supported this with nods and smiles and I wondered if I led the mentors by expressing my approval. The technique of

summarising participants' responses is also denounced by Morse and Field (1996) on the grounds that it can make participants feel self-conscious. In the transcripts, I found examples of myself doing so, all in an effort to ease the discourse. I took some comfort from other novice researchers who wrestled with similar challenges (Carolan, 2003, Hand, 2003). Wilde (1992), discussing the relationship between researcher and informant in qualitative research, proposes that interventions by the researcher, far from being undesirable, can open up avenues of enquiry previously unexplored adding a richness to the research. I set out with the intention of trying to establish a dialogue when I began my interviews, attempting to achieve 'a conversation' with mentors in which they could speak freely. Stroh (2000) argues that attempts at conversation should acknowledge that, to varying extents, bias and subjectivity will play a part just as would be the case in 'normal' or 'natural' conversations. Holstein and Gubrium (2004) describe the 'active interview', suggesting that there should be explicit recognition that both participants in the interview are implicated in meaning construction. They thus cast bias in a new light. Reflecting upon my own part in the interviews has led me to appreciate that rather than 'contaminating' the data, I contributed to the 'meaning' that was constructed by us both together, in keeping with the naturalistic paradigm I had chosen to adopt.

I was grateful to mentors for giving up their time to meet with me, for some the experience seemed to have some benefits, with my questions sometimes opening a 'flood-gate' of dialogue. Gloria felt that our interview sessions were 'cathartic' and a number of mentors commented that they found the sessions therapeutic.

For example,

> *That is why I like coming and telling you things....when you speak it through yourself and you think it through, you think well it was o.k. to do that so.. that's why I like to come here.* *Fiona, interview 2, 67-72*

I felt pleased that mentors felt able to speak openly with me and that I was generating rich data from my research. Other researchers have reported that interviewing can be a positive experience for respondents. Oakley (1981, p.50) describes the impact of her interviews on women in the peri-natal period, respondents commented upon the therapeutic effect of 'getting it out of your system'. I was aware that for the mentors in my study there were sometimes sensitive issues that might cause distress in their telling, for example, dealing with failing students. Therefore, at the end of each interview I gauged the situation, prepared to offer referral to staff support services as required. This proved not to be necessary. However, it did increase my realisation that mentors might benefit from the opportunity to discuss their mentoring experiences.

Documentary Research

Documentary sources are often used in qualitative research. They can include a wide range of personal and official materials such as diaries, letters and reports. I decided to ask participant mentors to complete a diary when they next mentored a student. I asked them to do so for the duration of one episode of mentoring, that is, for a maximum 12 week student allocation. My rationale for the use of diaries was twofold. Firstly, as a data gathering tool, diaries seemed to offer many advantages in helping address my research questions. They offered a means of generating data produced by mentors themselves whilst they were engaging with

students in clinical practice. I asked that mentors complete their diaries 'contemporaneously' on a daily basis when time permitted. Diaries thus had the potential to provide insights that might not have been forthcoming by means of interview, as diaries are less affected by recall bias (Bowling, 2009). Importantly, diary research seemed appropriate for the grounded theory methodology I had chosen to adopt, providing direct access to the mentors' perceptions of their role and their lived experience. I planned to analyse the reflective data generated from the diaries according to the principles of a grounded theory approach, substantiating data generated by interviews and moving me towards saturation of categories that had evolved from the data. I had rejected the idea of direct observation of mentors because it was potentially intrusive in clinical areas, difficult to co-ordinate, time consuming and not directly congruent with my grounded theory approach. Diaries seemed to offer an alternative solution as they can serve as a proxy for direct observation (Robson, 2002). I liked the notion that diarists would be almost 'co-researchers' if given appropriate instruction on what to record to help meet my research aims. Diaries usually deal with behaviours rather than emotions. However, they can be adapted to suit a variety of purposes (Bell, 2010). I sought to utilise this flexibility and set about devising a diary format in which mentors could record their mentoring activities and reflections, providing me with access to their thoughts and attitudes (Appendix 13). I noted from reviewing the literature that diary research had been used successfully in nursing research (Baglin and Rugg, 2010).

The second reason for utilising diaries as a research instrument related to my personal objectives in undertaking this project. I wanted to enhance my research skills and felt that I could broaden my repertoire in the use of data gathering tools

by using a documentary data source. I was also very aware that this project was undertaken in an effort to gain an academic qualification. I was worried that a study relying on interview data alone might not generate a sufficient volume of data, and the use of only one data gathering tool might not impress my examiners. In retrospect, I now realise that these fears were unfounded.

Diary research did not provide a panacea in terms of data collection. However, by using diaries with a committed group of volunteers I hoped to minimise problems. Those who are 'press-ganged' into completing diaries, a potentially irksome task, are unlikely to complete them thoroughly, if at all (Bell, 2010, p.178). I provided detailed written instructions, a 'sample' diary, (Appendix 13), and verbal briefing to guide mentors in providing the type of reflective material I sought. Instructions must be explicit when asking participants to complete diaries (Bell, 2010). The diary format was devised to encourage reflective accounts in the open 'comments' sections on a daily and weekly basis. I hoped to generate data pertaining to time that mentors spent undertaking mentoring activities with their students in the 'week on one page' sections. As mentors are busy clinicians, they made only brief diary entries. I was able to note core mentoring activities but unable to make estimates of time spent engaged in them. The 'free response' comments were transcribed and coded in the same way as data generated by interview and provided some interesting insights, helping me move towards saturation of categories.

When documents are used in research they have frequently come into existence for another purpose and are then accessed and analysed by researchers to inform their studies. In such a situation researchers must carefully consider the quality of this documentary data. Bryman (2008) suggests that four criteria are used for

doing so; these are authenticity, credibility, representativeness and meaning. Although the diaries were produced at my request as a data gathering tool, I considered them in the light of Bryman's criteria. With regard to authenticity, I was confident that the material was generated by specific mentors as I could identify the handwriting of all. However, doubts existed regarding credibility. The data generated from diaries was produced specifically for the purpose of my research and as such the data did not hold the advantage of 'non-reactivity'. In other words, a major problem for me to consider was the extent to which completing a diary had altered the mentors' behaviour (Oppenheim, 1992). Mentors might seek to present themselves in a better light by documenting activities with students that they would not normally undertake. I hoped to minimise this by discussion at my verbal briefing with mentors. With regard to representativeness, I was struck by the similarity of the diary entries, despite the distance between mentors and different working environments. In total, I collected data from 8 diaries, all of which recorded similar activities. I am therefore confident that the data is typical of its kind. As diaries were kept over a period of several weeks, I felt this more likely to capture a broad span of usual activity than if I had collected shorter 'snapshots' of a day or week that may have been atypical. There have been some difficulties with comprehensibility in that occasionally handwriting has been difficult to decipher. In addition, most diaries were only very partially completed, with some weeks devoid of any entries at all. Mentors adopted different styles in the way that they recorded material. For example, some provided detailed, reflective accounts in the 'first person' whilst others adopted a more detached approach, writing with the reader in mind. I had suspicions that the mentors completed the diaries retrospectively, possibly just before I was to collect them, as most were filled in with exactly the

same ink. I may be incorrect in this assumption, as one mentor explained to me during an interview session,

> *'Actually it was really helpful. I used it in my own way that after every shift that I had done with the student, I actually just dated it and kind of said what had happened in the day. .....but certainly doing the log everyday was a good way to look back and reflect really'.* Irene, interview 2, 14-27

Overall, the diaries have provided information regarding the range of learning experiences to which students are exposed. The 'open comments', whilst variable in their quality and quantity; have added some insights into mentor experience that helped to substantiate my findings. If diaries were completed at some time later, as I suspected, the advantages of more contemporaneous accounts would be lost but the quality of reflection still provided further access to mentor perceptions. The data from the 'open comments' sections were transcribed and analysed in the same way as the interview transcripts, using a grounded theory approach.

Rigour and trustworthiness

In quantitative studies the extent to which findings are deemed 'valid' and 'reliable' is determined by the objectivity with which data gathering tools are administered and bias is controlled. The situation is rather different in qualitative studies such as mine, where the tools of data collection are not predetermined or standardised. Furthermore, the researcher is an instrument of data collection and analysis and contributes to the construction of knowledge with the participants. This has led some authors to suggest that 'Trustworthiness' is more appropriate as a means of assessing the quality of qualitative research (Guba and Lincoln, 1989). Parahoo

(2006, p.410) claims that researchers are 'still grappling with what constitutes rigour in qualitative research', a point also made by Tobin and Begley (2004). A number of strategies have been utilised, for instance, audit trail, reflexivity and validation by experts and /or participants to ensure rigour (Koch, 1994). In qualitative research, terms such as 'credibility', 'auditability' and 'transferability' are preferred to those of validity, reliability, objectivity and bias.

Credibility

The core element of a credible study is that the author has provided enough description of the methods, the participants, interactions and decisions taken so that the reader is convinced of the believability of the study because the 'integrity of the findings are rooted in the data themselves' (Guba and Lincoln, 1989, p. 243). In this report I have attempted to convince the reader of the credibility of the study by providing a detailed account of the methods I employed in collecting and analysing the data, with richness of presentation and discussion of findings.

Credibility refers to the extent to which findings are believable and judged as accurate by both the research participants and independent experts. To address the extent to which the participant mentors felt my study reflected their experiences, I made short 'Power point' presentations at 'mentor update' sessions as my data analysis progressed. Mentors told me that they could recognise my interpretation of their experience as their own, that I had 'got it right'. Such 'member checks' are 'the single most crucial technique for establishing credibility' according to Guba and Lincoln (1989, p.239), a view endorsed by Polit and Beck (2006). I felt that such an approach was an appropriate way of 'member checking' to enhance the credibility of my research. I considered seeking more detailed,

individualised feedback from mentors but rejected this. Difficulties can arise in participant validation, for example, in how to resolve disagreements between participants (Sandelowski, 1998). I decided that I had taken adequate measures to broadly gauge mentors' views on my interpretation of the data, balanced against this potential difficulty of resolving a protracted dispute.

I did not discuss my work with external independent experts as I had access to my supervisors, established experts in the field of practice education. They provided on-going feedback as they scrutinised my work as I submitted twelve project reports throughout the progress of the research. I also received detailed feedback from the wider EdD team following submission of my Year One report. I decided that this was robust and adequate feedback bearing in mind the issues that Sandelowski (1998, p.467) raises regarding 'expert validation', questioning whether even those with very impressive credentials are 'in any position to certify as valid the findings, descriptions, categories, theories, or meanings in studies in which they played no intimate part'.

The personal credibility of the researcher has an important contribution to the credibility of the research overall. This is because the researcher is seen as central to data collection, analysis and reporting. By making qualifications and experience explicit, the researcher can help to convince the reader that they are a trustworthy researcher (Riley, 1996). I have been registered with the NMC as a Lecturer and Practice Educator for 10 years. In this role I have closely supported mentors and students in both acute and community settings. My Master's degree in Education was undertaken during this period, this included a small study exploring students' experiences of learning in clinical practice. Prior to this I held

the role of mentor as staff nurse and midwife, demonstrating experience in practice education spanning many years. By making my 'credentials' explicit in this way I hope to enhance the credibility of the study.

As I have alluded to above, the Open University's EdD programme is very structured, with formal reports submitted on a regular basis. Hence the level of scrutiny is intense as the on-going research is monitored very closely. This adds to the credibility of the findings.

Auditability

Auditability refers to the ability to track the research data. It also refers to each of the steps of the research process being clearly described so that an independent researcher can critique the research from its beginning to the analysis and interpretation of the data (Polgar and Thomas, 2008). This would entail a second party auditing the decisions and analytical processes of the primary researcher. Parahoo (2006) states that auditing all the actions and decisions of a qualitative researcher is an impossible task. Furthermore, Cutcliffe and McKenna (2004) argue that the absence of an audit trail does not necessarily challenge the credibility of qualitative findings. As this research was undertaken as part of an EdD programme, I did not ask another researcher to audit my work, having feedback from my supervisors as previously described. However, throughout this report I have provided details and the rationale for the key decisions that I have made. I have also provided detailed examples of how coding has taken place and themes and categories derived from the data, with labelling of all data permitting tracking to their original source. I have done this to demonstrate transparency in the way that I have conceptualised the data.

Transferability

Transferability or 'fittingness' is the extent to which the findings of a grounded theory study can be of use to other populations or settings similar to those in the study (Parahoo, 2006). The researcher should provide sufficient contextual information to make judgements possible by others (Guba and Lincoln, 1989). In this final report I have set the context in which this research was conducted, describing the remote and rural island setting. I have provided detail of the participant mentors and their areas of practice. I have I also provided detail of how the data were gathered, analysed and how findings were conceptualised. Judgements can then be made by readers as to the transferability of the findings.

Data Analysis

Interviews and diaries generated qualitative data; in this section I discuss my analysis of this data. I begin with a description of how data were transcribed and then provide detail of how coding of the data was undertaken.

Transcribing the data

My first step in analysing the data was to ensure that I had each transcript identified correctly whilst maintaining anonymity. I then numbered each line of text in each transcript and numbered each page. My decision to transcribe the data myself rather than employ an audio typist paid dividends in that I became very familiar indeed with the data, essential when adopting a grounded theory approach. Whilst transcribing I had the opportunity to jot down initial thoughts

about what was being said and identify potential codes. Also, although time consuming, I was confident that my painstaking approach had produced a very accurate transcript. Dave Ebutt (cited in Powney and Watts, 1987, p. 105) describes his frustration at having to correct the 'free and highly imaginative interpretation' of an audio typist he employed. I read and re-read the interviews with the audio tape playing as a final check for accuracy. I noted on the transcript any nuance, emphasis or particular tone of voice that I felt was important in conveying the intended meaning or capturing the demeanour of the interviewees. I sent copies of the transcripts to participants. I did this to offer them the opportunity to confirm the accuracy of the texts and also to generate a sense of 'ownership' and inclusion; no amendments were made as a result. Qualitative data from the diaries were transcribed and analysed in the same way as the data generated from interviews.

The coding process

I began the coding process as soon as I had transcribed my first interview using an iterative process of questioning the data in a systematic, detailed way. Coding entails reviewing transcripts and allocating 'labels' to those aspects of the data that seem to have potential significance. They are a shorthand way of helping label and organise the data. I recognised that in adopting a grounded theory approach, my interpretation of the data would influence the emergent codes. I planned to check my interpretation with participant mentors as analysis progressed. In keeping with Strauss and Corbin's (1998) recommendations, I progressed through the three stages of open, axial and selective coding.

There are a number of computer software programmes available to assist with qualitative data analysis, such as NVivo. The computer takes over the 'manual labour' involved, such as making marginal notes and physically cutting and pasting data. However, I considered that I already had most of the cutting and retrieval features that I required using 'Word for Windows' bearing in mind that my data set was not massive. There were also the advantages of not having to purchase, install and learn to navigate my way around new software when I was feeling under pressure and deadlines loomed. Furthermore, there are some perceived disadvantages to the use of 'Computer Assisted Qualitative Data Analysis Software'. These criticisms centre on the fact that the use of such software can result in an exaggerated degree of fragmentation of the data. The consequence being that the narrative flow of transcripts can be lost (Weaver and Atkinson, cited in Bryman, 2008) and this can adversely impact upon the context in which data are viewed. Taking this into account I decided to analyse my data manually.

Open Coding

I began by using the open coding process, described by Strauss and Corbin (1998), on the first interview transcript, having first labelled each page and numbered each line for subsequent references and auditing, as I have described above. As I worked through the transcript I underlined words and phrases that seemed significant and relevant to my research questions and I made comments in the margins. I assigned preliminary codes to short phrases or significant words. I made summaries of each transcript in words, and I used 'Mind Maps' as a means of summarising interviews and assimilating some of my initial thoughts (Appendix 14). I found 'Mind Maps' useful in helping to organise my thoughts, Buzan (2003, p.11) describes them as the 'Swiss army knife for the brain' and advocates the use

of mind maps to help create order from chaos. Open coding is so called because it opens up the text in order to expose 'the thoughts, ideas and meanings contained therein' (Strauss and Corbin, 1998, p.102). I generated these preliminary open codes very freely (Appendix 15).

I used quotation marks around some codes to indicate that they were derived from the actual words of mentors, so called 'en vivo' codes. In this way, codes were generated from short phrases or individual words with some data having more than one code assigned to it. At this stage I did not discard any data, rather I tried to code and comment upon everything as Glaser and Strauss (1967) say that ideally all data should be accounted for.

The constant comparison approach

I examined the transcript from the next interview and all the interviews conducted thereafter, with the first interview in mind and compared one with the other. In this way I developed and added to the open codes as I went along, conducting interviews, transcribing the data and then comparing one transcript with the other. As I worked through each transcript, comparing one with the other, I noted what I thought to be any inconsistencies, contradictions or any common themes that seemed to be emerging. 'Constant comparison' is a process requiring the researcher to compare incidents in the data with one another and to the literature in order to develop codes, identify their properties and in due course develop core categories (Glaser and Strauss, 1967). It is a means of maintaining a close connection between data and conceptualisation. To help with the process of constant comparison I developed a database for each code, with quotations from each transcript. (Appendix 16). Doing so helped me to identify patterns,

similarities and differences in mentors' experiences as I interrogated the data. My analysis and thoughts were recorded in the form of memos, discussed in more detail below.

Axial coding

I began the process of axial coding by looking for relationships and connections between the codes that had been established during open coding. I did this by re-examining my transcripts and codes in a very focused way, establishing potential links between codes and then considering carefully what such links meant. My aim was to establish more abstract 'categories', encompassing more than one code, at a higher conceptual level. In this way I was 'reassembling data that were fractured during open coding' as described by Strauss and Corbin (1998, p. 124). I was attempting to put the data 'back together again' in a new way that took into account the relationships between codes. To help in this process of establishing relationships between codes I interrogated the data asking such questions as, how are mentors supporting students, why are they adopting a particular approach, what is in it for them, what are the consequences of their different approaches? This was congruent with the 'paradigm model' advocated by Strauss and Corbin (1988, p.128) described by them as 'nothing more than a perspective taken towards data, another analytic stance that systematically helps to gather and order data'.

Selective coding

Having been so immersed in the analysis of my research data for a lengthy period, by this stage I felt that I had a 'gut' sense of what my research was all about (Strauss and Corbin, 1998, p. 148). I tried to articulate this in memo format by

writing a storyline to help me to understand 'what seems to be going on here' as advocated by Strauss and Corbin (1998, p.148). This was important in helping me to try to identify an explanatory core category or central concept. I was seeking to identify a central concept, the key issue around which all the other categories are integrated.

Memo writing

Writing memos was an integral part of the process of analysis. According to Strauss and Corbin (1998) there are no wrong or poorly written memos. They point out that they are unlikely to be seen by anyone other than the analyst. This was reassuring because I was sure that my memo writing was of a poor literary standard! However, memos provided an important function in that they helped me to record the progress of my research, my thoughts on emerging categories and sometimes my feelings on how the research was progressing. My memos took a number of different forms. I began with summaries of interviews, written from my 'mind maps', 'margin' notes and my initial impressions of interviews. I also wrote memos in the form of 'code notes' that explored my thoughts relating to how codes had been defined and how my ideas evolved and changed as I revisited them on subsequent readings of the transcripts. These served as 'memory joggers' to record my initial ideas as I was working with the data.

Appendix 17 illustrates the process by which I gathered and analysed the data. The disadvantage of such a diagram is that it makes it appear that each stage is distinct and separate and that analysis was undertaken in a precise and ordered way. The reality was very different as grounded theory methodology stresses the

very cyclical nature of the process. I moved from different levels in a very flexible way as I struggled to conceptualise what the mentors were saying.

Presentation of findings

I considered very carefully how to present my findings. I reflected upon how my decisions as an author would impact upon how my findings were conveyed to an audience. Jackson (2000) challenges researchers to consider such issues as how data are attributed, the extent to which data are 'cleaned up' and whether it is acceptable to rearrange extracts to support a particular point. I considered presenting 'vignettes' of mentor activity (Miles and Huberman, 1994) but decided that the best approach to present the data clearly would be to organise it around the categories and subcategories that emerged from the data. Clearly attributing data to individual mentors and adhering to accepted conventions indicating gaps in the narrative were important in representing the data accurately. I hoped that by providing detailed examples of how coding had taken place and how categories and elements were derived I would be transparent in demonstrating how I have conceptualised the data.

Conclusion

In this chapter I have presented the research design of the study. To explore the experiences of mentors supporting pre-registration nursing students a qualitative approach was adopted guided by the principles and procedures of grounded theory.

The purpose of the study, to increase understanding of the experiences of mentors directed my choice of a qualitative methodology. Such an approach allows for the inclusion of rich information that might be excluded had a positivist paradigm been adopted. The main source of data was one to one interviews. Interviews provided detailed insights into mentors' experiences. Data gathering by means of diaries also provided insights and helped to move me towards saturation of some categories. Data were analysed according the principles of grounded theory utilising constant comparison. 'First round' interviews being conducted and compared one with the other, data analysis commencing with the very first interview. Data from diaries contributed to development of categories and all of this data shaped 'second round' interviews. The coding process began with open coding, to 'open up' the data and proceeded through axial and selective coding, each stage taking the data to a higher conceptual level. The final stage was to collect core categories together under one central category, 'Fostering student learning'. In the next chapter I go on to present the categories and subcategories that capture mentors' experiences of 'Fostering Student Learning'.

4. What Mentors say about their role

In this chapter I present the themes that emerged from interviews with 10 participant mentors and from diaries kept by 8 of these mentors. My aim was to identify their experiences of supporting learners and to understand their role in promoting professional development so that students meet the requirements of the NMC (2004) for registration. One to one interviews provided access to a rich seam of material regarding mentors' experiences of their day to day interactions with students and to personal reflections on their wider mentoring role. The diary format provided the opportunity to generate detailed data, gathered contemporaneously, providing information about mentoring activities, as well as reflective accounts from mentors. Both data collection methods were congruent with a grounded theory approach, providing access to the experiences of mentors.

From the data I identified 3 categories, 'Having a student', 'Passing it on' and 'A surrogate family'. Each of these categories had a number of subcategories; see over, **Table 4.1**

Categories		
'Having a student'	**'Passing it on'**	**'A surrogate family'**
	Subcategories	
'It's part and parcel of nursing'	A good placement	'A mother and her child'
'Commitment'	Establishing learning need	'Sussing them out'
'It's good for us'	'Showing them right'	A new family member
'A big responsibility'	Giving feedback	
The feel good factor	'Speaking them through'	
	'Pride and passion' – promoting the essence of nursing	

Table 4.1 Categories and subcategories derived from the data

I now go on to present these categories and subcategories using examples of data from the interview transcripts and diaries. The source of each quotation is clearly attributed, with mentors having been ascribed a pseudonym and line numbers indicating the location in the transcribed text, to facilitate tracking back to the original transcript.

'Having a student'

The category 'Having a student' emerged from the transcripts as mentors described the thoughts, feelings and emotions that supporting a student meant to them. The following 5 subcategories are related to this category:

- 'It's part and parcel of nursing'
- 'Commitment'
- 'It's good for us'
- 'A big responsibility'
- The feel good factor

'It's part and parcel of nursing'

The participants seemed to view their role as mentor as integral and fundamentally important to the way in which they viewed themselves as nurses. Their perceptions of how they first took on the role seemed not to be dependent upon undertaking a mentor preparation programme. Rather, regardless of when they had been admitted to the formal mentor register, it seemed that participants saw supporting students as core to being a registered nurse from the start of their careers, as Betty and Heather indicate:

> *'It's just something... students... were always there, so you were used to having students most of the time, it's just part of nursing isn't it? To have nursing students working alongside, I think it's something we're all used to now and you just expect it...it's part and parcel of nursing...'* *Betty, interview 1, 10-14*

> *'I don't think that there is really a down side to having a student, I think that's because it has always been part of our role, I don't really think that there is such a thing as a 'mentor' to be honest. I think that in nursing you*

always mentor everybody, even your patients (laughs); do you know what I mean?' Heather, interview 1, 317-320

The Code (NMC, 2008b, p.4) states that all registered nurses must 'facilitate students and others to develop their competence' and these mentors seem to be reflecting this, 'having a student' is what they expect as part of their nursing role. Nettleton and Bray (2008) found that respondents felt that being a mentor was part of their 'job description' but that most were happy to take on the responsibility. In the current study, Gloria, an experienced nurse who undertook a formal mentor preparation programme 4 years previously, seems to be suggesting that student support is intrinsic to her nurse persona,

'I suppose, really, officially, I have only been a mentor, is it about 3 or 4 years, yes as an official mentor... Whether you are directly their mentor or whether they just happen to be passing through where you are working, you should really be mentoring all the time if you are qualified'.
Gloria, interview 1, 13-16

Participant mentors seemed unconcerned with titles and roles 'officially' ascribed to them,

'I could say I've had students just about all the time I've ever been a staff nurse. When actually the name mentor came along, I can't remember but basically I've always enjoyed the students so I think that I've always actively seeked out to get students. So em, I think I've had students for about 15 odd years, but I can't actually remember when the name mentor appeared'.
Chris, interview 1, 11-16

This concurs with a study by Neary (2000a) who found that practitioners' concerns lay not in what they were called but in how to teach, assess and support students more effectively. Although academic debate regarding the role and remit of the mentor has spanned several decades (e.g. Donovan, 1990, Morle, 1990, Anforth, 1992, Neary, 1997, Bray and Nettleton, 2007), the mentors in this study seemed to take a detached approach to these changes. They appeared blasé regarding formal titles and seemed accepting of student support as intrinsic to what they do. The data presented within this subcategory seem to indicate that participants embraced student support and embedded it into their role early in their careers. This is important as mentoring, a complex and challenging role, requires highly motivated nurses in order to carry it out effectively (Pulsford et al., 2002, Myall et al., 2008). Atkins and Williams (1995), in their small investigation of 12 mentors note the distinction between mentors who regarded mentoring as integral to their role and those who saw it as an additional responsibility. The former regarding it more positively and this would seem to be borne out by my findings. Mentors in this current study seemed to regard mentoring as 'part and parcel of nursing'. Viewed in such a way, integral to their registered nurse status, seemed to be powerful in driving their commitment to the role.

Commitment

This subcategory emerged from the data as personal commitment seemed to be viewed by participants as an essential component to the success of the mentoring relationship. Participants seemed to demonstrate their commitment to the role in terms of time they devoted to it and their declared interest in education and the

facilitation of learning. All the mentors spoke of giving up their own personal time to fulfil their mentoring obligations,

> *'I am very lucky in the aspect that I bide in X town, so if there was a student that I didn't get a chance on the ward with... I can nip in. I've had to do that a couple of times ...because I will be honest, getting time, an hour off the ward, is just not possible a lot of the time'.*
>
> *Irene, interview 1, 147-155*

This supports findings of Pulsford et al. (2002) and Dolan (2003) who found that aspects of mentoring are sometimes undertaken in mentors' own time. Some of the participants in this study gave students their personal mobile telephone numbers so that they could access support out with working hours. They described how they attended mentor updates on 'days off' if there were insufficient resources to release them during 'on duty' periods, a point also noted by Nettleton and Bray (2008). Interest in practice education and commitment to the role are regarded as significant determinants of success in the mentoring relationship (Andrews and Chilton, 2000, Myall et al., 2008). Here we have examples of mentors 'going beyond the call of duty', giving their own personal time to support students. The literature reveals that students very much value mentors who show concern for them as individuals and are willing to spend time with them (Gray and Smith, 2000).

It might be argued that mentors' motives are driven not by commitment to the role but rather as a means of enhancing job prospects (Watson, 2004). A mentor qualification provides evidence that core dimensions of The Knowledge and Skills

Framework (Department of Health, 2004) have been met. Evidence from participants in this current study seemed to indicate that career aspirations were not the key motivator and that commitment to the role sprang from more personal sources. All acknowledged that supporting students could be problematic but all wanted to maintain their mentor status. Chris identified that effective mentors had to do more than just 'go through the motions',

> *'...you might get mentors who do the job but their heart isn't in it...'*
>
> *Chris, interview 1, 42*

The literature bears witness to the poor mentoring experiences that students have sometimes endured as a result of lack of mentor commitment to the role (Gray and Smith, 2000, Duffy, 2003). For example, in Gray and Smith's (2000) study, students encountered mentors who broke promises, chopped and changed their minds and delegated unwanted jobs to them. They had little interest in education and a poor understanding of the pre-registration programme that led them to throw students 'in at the deep end'. The students noted that poor mentors often disliked their jobs. By contrast, the participants in this current study seemed to enjoy their nursing roles, viewing mentorship as a core and enjoyable aspect,

> *'I like working with the students and er .... I love nursing very much and I really take an interest in them because I would like them to turn out to be good nurses. I feel because I have quite a few years of experience that I should be quite good at doing that'. Dora, interview 1, 14-17*

Dora seems to epitomise participants' views indicating a positive attitude and commitment toward supporting student learning. An explanation for this might be that these participant mentors joined the study because of their interest in practice education. Those who did not might be less committed to the role. My questionnaire, discussed in the introductory chapter as background to this study, with its disappointing response rate of 39%, raised more questions than provided answers in this respect. Those who responded seemed to demonstrate an interest in student support but more than 60% of mentors did not respond and whose views were therefore not reflected in these results.

'It's good for us'

This subcategory evolved from the data as mentors seemed to identify a number of personal and professional benefits that accrued to them as a result of 'Having a student'. For example, students could provide a 'boost' to slightly 'jaded' mentors; they were viewed as a learning resource and an impetus to maintaining high practice standards. What emerged from the transcripts was a sense that mentors overwhelmingly viewed mentorship in positive terms. Very rarely, 'It's good for us' hinted at a sense of penance as mentors described the hard work involved in supporting a student. Despite this, the presence of a student seemed appreciated for the rejuvenating impact this could have on the individual mentor,

> *'..that is what I find about students, it's almost like pressing the refresh button on the computer when you are on the internet, if you can't get a site, it makes you sit up and think, well you know there is more to my job than just slogging it in day in and day out'.* Fiona, interview 1, 85-88

In small teams, particularly in remote community placements, the addition of a student could have a very noticeable impact on the dynamics of team working,

> *'I think that it is good for everybody, good to have new blood, new faces.., we don't have to stare at one another... (laughs) Yes, we get to meet some lovely folk, who want to come back...'.* Irene, interview 1, 433-436

Mentors seemed to be saying that a student, possessed of vitality and enthusiasm, could give a boost to energy levels of the individual mentor and wider team. Irene is also suggesting that students, having been introduced to how care is delivered in a remote and rural setting, might want to return. This was a point raised by other mentors who saw this as laying the seeds for future recruitment and as a potentially tangible return on their 'investment' in their mentees. This seemed to be perceived as 'good' for the individual mentor and 'good' for the wider organisation.

The mentors seemed to regard students as an impetus to maintaining high practice standards and an incentive to keep up to date. Participants wanted to ensure that their practice was evidence based and that they demonstrated the highest professional standards to their students, aware that they would be scrutinised and possibly challenged by them. Participants described how mentoring students encouraged them to interrogate their own practice as Betty describes,

'I think that we sort of all realise that yes that's all very well but it is quite good for us to have students because it does keep you on your toes and you do think about well actually 'Why am I doing it and why am I doing it like this?' and they ask questions and challenge you a bit. So it's good, it's not always convenient to have students but I think it's very good as well. ..they can ask the most strange questions that you think 'God, I never thought of that". Betty, interview 1, 17-25

Students were also regarded as a 'learning resource' as Betty later describes,

'One student I had, she'd been on another community placement, and oh we were talking about a particular awkward leg ulcer that we'd tried different things and she said 'where I was before we tried such and such dressing', and it was a dressing that I had never used before. And she described it to me, she described how it worked, so we decided to get it, to get it on prescription and to try it and it worked. Because, you do use the same things, you use what you are used to and do what you are used to doing because it's sort of tried and tested, and then you do rely on other people for different information'. Betty, interview 1, 45-53

This seems to corroborate the findings of Carlisle et al. (2009) who found that mentors appreciate students for what they can contribute. Student contact had benefits in other ways, as mentors seemed to derive learning and satisfaction from the process of mentoring itself, as Heather indicates,

'...they tend not to have been indoctrinated into nursing attitudes, if you like, so that they are very flexible in their thinking and I enjoy that quite a lot and the fact that because they have to learn so much, I have to learn so much and find different ways to get that over to them is very stimulating'. *Heather, interview 1, 42-45*

'If you see that they are struggling to either take in a concept or perform a task in a certain way, you have to think, how else can they do it and still be safe if you like em ... so it gives you a lot of different options for yourself as well'. *Heather, interview 1, 357-359*

Here Heather seems to be reflecting upon her own mentoring skills. Having identified that a student is having difficulty, she is debating the different means by which she can convey her knowledge and skills to help the student. She seems to be enjoying this element of mentorship as she considers the most appropriate means of facilitating student learning. Mentoring students seemed to be viewed as a way of honing skills that, once developed, might be transferable to different situations,

'..it has definitely been good for me as a nurse in maybe hopefully in future years being in a senior position, because you are going to have.. it's not just going to be students that's going to be problems, you are going to have issues with staff members, staff and colleagues are going to have issues and it's being able to provide them with that support and knowing how to deal with it'. *Irene, interview 2, 209-213*

For participants mentoring a student seems to have benefits professionally, as students seem to be regarded for the new information they bring and the way in which they act as a spur to ensure that practice is evidence based. The data suggests that participants also seemed to view mentoring as a way of enhancing their interpersonal and problem solving skills. On a more personal level the mentors appeared to enjoy the company of a new team member, this was particularly noted in very small teams. Thus, contact with students had many benefits in terms of enhancing team morale, developing the interpersonal and leadership skills of mentors and in enhancing care to patients, points made by Hall (2006).

'A Big Responsibility - Pressure and Stress'

This subcategory evolved as mentors provided detail of what they seemed to consider as the personal responsibility they must bear in order to facilitate effective learning and make appropriate assessment decisions for which they are accountable.

> *'....during the training [to be a mentor] you actually realise how much responsibility it is that you have taken on...'.Jacqueline, interview 1, 89-90*

It seems that for Jacqueline, the mentor preparation programme crystallized her understanding of the mentor role and what this would entail. The 'Standards to support learning and assessment in practice' (NMC, 2008a) set out clearly the responsibilities and accountabilities expected of those who undertake the role.

Jacqueline seems to be alluding to the fact that this can seem rather overwhelming. With the increased emphasis on assessment as part of the mentor role the level of accountability for decision making is increased and this can add to the pressure experienced (Nettleton and Bray, 2008, Myall et al., 2008), given the environments in which mentors work. All of the participants stated that 'Having a student' increased their responsibilities and as a consequence increased the pressure or stress that they experienced. This seemed compounded by what they felt was insufficient time in which to carry out the role, particularly apparent in acute clinical areas where the ratio of registered nurses to health care support workers (HCSWs) is increasing as a result of funding pressures (BBC, 2011). This might result in fewer registered staff available to take on the mentor role and increased workload for registered staff in post as they supervise care provided by an unregistered workforce. Here Irene provides an insight into the difficulties of trying to provide appropriate support for her student,

> *'....but there were often days that I was in charge and being a first year student, they need a lot of support, they need somebody there and they need to explain it. And when you have social work to phone, home care to phone, the ward round to do, it is difficult, ...'.* Irene, interview 2, 142-145

In this quotation Irene highlights some of the everyday demands she faces when supporting a student, in this case a very junior and inexperienced student. The student will need constant support and supervision. Here, Irene is torn between the demands of being the registered nurse, responsible for supervising the staff on duty whilst attending to the doctors' rounds and contacting external agencies so that patients can be discharged. We do not know if Irene has another registered

nurse to support her. It could be argued that Irene might delegate her work more effectively, though this would be difficult if she was the only registered nurse on duty. She might have allocated an experienced HCSW to work alongside the student as a strategy to lessen pressure in the short term. That said, all of the mentors commented upon the additional pressures that mentoring brought and this is borne out in the literature. Kenyon and Peckover (2008) describe the 'juggling act' that has to take place in order to meet the needs of both students and clients. Students in Gray and Smith's (2000) study note that mentors were pushed and pulled in all directions. Spending time with students has been identified as essential in helping students to develop clinical, personal and professional skills (Lloyd Jones et al., 2001). The mentors in this current study described how they struggled to fulfil their mentoring responsibilities due to pressures of time and competing responsibilities. This was exacerbated for those mentors who deputised for senior staff and had to support junior staff members as well as students. Hutchings et al. (2005) have drawn attention to issues of student capacity as being an area of concern. In the current study participants spoke of the constant and apparently increasing flow of students through their clinical areas. This was noted particularly in small teams, who felt that they rarely had a break from their mentoring duties as there were fewer mentors with whom they could share the burden. The mentors described feeling under constant scrutiny, their every move being observed and being bombarded by a continuous stream of questions from which there was no escape,

> *'Because it is some days just, Oh... gosh, because you do get ones that need you 110%, you do get ones, and it can be very tiring 'Why are you*

doing this, why, why, why?'.. It can be stressful at times'. Irene, interview 1, 378-379

This was particularly onerous for those in very small community teams, who had intense one to one relationships with their students, as Heather describes,

'You are having to think all the time, you are having to be 'on' all the time, em instead of the usual mental break between patients, which you can sometimes do to de-stress from one patient to another, I guess, you don't get the opportunity to do that because you are having to go over what went on with the last visit and what is going to happen at the next visit'. Heather, interview 2,194-198

In the very small community teams of my study, mentors are working in close proximity to their students, directly supervising them at all times, as Heather describes. There are fewer clinical colleagues with whom to share responsibility. This concurs with Kenyon and Peckover (2008) who note that these elements of time and space are features of community placements. Furthermore, very remote placements presented some unique logistical challenges for mentors. Students had to travel long distances, often involving ferry crossings, to arrive at their placements. Co-ordinating travel arrangements, especially during inclement weather was time consuming and sometimes stressful for mentors, adding to the 'juggling acts' in which they had to engage in terms of organising workloads. Baillie (1993) notes that if students are tired from travelling this can adversely affect their learning. All of this seemed to add to the daily pressures of supporting a student in a remote setting. Of course, mentors tried to access support from

colleagues when possible to reduce pressures upon themselves but even in areas where this was possible, it tended not to be a panacea, as Fiona describes,

> *'I felt to begin with I didn't see him as much as I would have liked and I farmed him out to other colleagues, ...maybe at the beginning I farmed him out too much because of my workload..... the pressures that I had on me to be doing other things, being at meetings and being involved in ... audits and things like that and I felt a bit guilty for that..'.* Fiona, interview 2, 228-236

Fiona is describing the way in which, due to pressures of work, she allocated her student to other colleagues. This induced feelings of guilt as she was not able to spend what she deemed as an optimal amount of time with her student, as Irene described. The negative impact of pressures of time upon the quality of mentoring has been identified in the literature over many years. Competing priorities, staff shortages, heavy workloads and excessive numbers of students have all been cited as causes of lack of time for mentors (Watson, 1999, Aston et al., 2000, Corlett, 2000, Pulsford et al., 2002, Aston and Molassiotis, 2003, Dolan, 2003, Carlisle et al., 2009). Paradoxically, although the data revealed the many pressures to which mentors were subject, all professed to enjoy the role and none expressed a desire to relinquish it. It seems that participant mentors rose to meet the responsibility of 'Having a student' and enjoyed the role despite the pressures of the role and feelings of guilt engendered in not being able to devote as much time to students as they would have liked.

'The feel good factor'

The data revealed the challenges in undertaking the mentor role, as discussed in the preceding subcategory. Rising to meet these challenges seemed to increase the self-esteem of participant mentors. This category 'The feel good factor' emerged from the data as mentors seemed to be describing ways in which mentoring students improved the way in which they regarded themselves on a personal level. Supporting a student effectively, seeing them develop personally and professionally appeared to result in enhanced feelings of worth for the mentor, a sense of satisfaction in a job well done. Data seemed to indicate that mentors viewed mentorship as a life affirming experience, positively enhancing the way in which they viewed themselves as nurses and as people. Linking with the subcategory 'It's good for us' described previously, 'The feel good factor' seemed to be a key motivator for mentors to 'Have a student' and maintain their mentor role.

Mentoring a student seemed to provoke powerful feelings in the participants, for instance, Fiona stated that being a mentor made her,

> *'...the better person and the better nurse...'* *Fiona, interview 1, 358-359*

Jacqueline felt that being a mentor had a fundamental impact upon the way that she saw herself,

> *'...yes there is a big positive thing having your student. It makes you look at your whole life of being there and doing this job. Isn't it? Yes, it's good'.* *Jacqueline, interview 2, 394-396*

Mentors spoke about a sense of achievement that derived from contributing to students' development, enhancing the way that they viewed themselves, as Irene describes,

> *'I like feeling that I am approachable to my students, and you get certain ones and they just come and ask you and I think that is a kind of positive thing about being a mentor because you think that you must be approachable'. Irene, interview 1, 236-239*

That students are not inhibited in seeking Irene's advice seems to have boosted her self-image and confidence in performing the role. This positive feedback seemed to matter to mentors at this very personal level, affirming the importance of the role and their contribution to student development. It seems that for the participating mentors there was much to be gained at a personal level from mentoring students. This concurs with the findings of a small study conducted by Kinnell (Kinnell and Hughes, 2010) in which mentors describe how the role has impacted upon them personally, affecting their thoughts, feelings and emotions in the way they view themselves and the world. This was a point also noted by Atkins and Williams (1995) where mentors described gaining personal insights as a result of mentoring students.

Summary of the Category 'Having a Student'

Mentors refer to 'Having a student' as a shorthand way of describing their mentoring relationship. It hints at a rather impersonal, casual approach to student

support. However, data presented within this theme depict an image of very committed mentors who take their mentoring responsibilities very seriously. They seemed to be blasé about titles bestowed upon them over the years by the professional bodies. They appeared to be more interested in getting on with the job of supporting students to the best of their ability, apparently considered intrinsic to their role as nurses. Participant mentors acknowledged the high levels of responsibility involved in supporting students in practice, for most this increased the pressure and stress they experienced. For some, feelings of guilt were engendered when they could not spend as much time with students as they wished. Participants also seemed to derive many benefits in terms of their relationships with students. These gains are seen in terms of how contact with students could enhance their professional skills and knowledge, hone their mentoring skills and importantly enhance self-esteem.

'Passing it on'

The category 'Passing it on' emerged from the data as the mentors described what seemed to be their core purpose in undertaking the role. This category captures what mentors seek to 'pass on' to their mentees. This relates to skills, knowledge and appropriate professional behaviours. 6 subcategories are linked to this theme,

- A good placement
- Establishing learning need
- 'Showing them right'

- 'Speaking them through'
- Giving feedback
- Pride and passion

A good placement

This subcategory emerged from the data as mentors seemed to be describing their views of what constitutes an effective clinical placement for student nurses. This seemed to focus on the 'atmosphere' that exists in the workplace and the culture that surrounds student support. The physical resources available in the workplace were sometimes mentioned by mentors as being important in contributing to a good student experience. However, overwhelmingly, it seemed that mentors considered the 'tone' or culture of learning as being the key determinant of an effective placement. The mentors seemed aware that they had a key role to play in cultivating such an environment, in which students could feel comfortable, as Chris indicates below,

> *'But if you don't create the environment for them to feel comfortable and ask, they're not going to learn anything, or it's going to limit what they learn and I think sometimes you can ... you have to focus on the formal work but you have to create the environment which makes them comfortable...'.*
> *Chris, interview 1, 76-80*

Here Chris is providing insights into the way in which the facilitation of student learning is approached. There is acknowledgement that the 'formal work' of helping students achieve set learning outcomes must be done. Chris seems also

to be aware that in order for this to occur most effectively, the student must feel welcomed and at ease in their new environment. This relates to a number of concepts, such as 'belongingness' (Levett-Jones and Lathlean, 2008) and 'sponsorship' (Spouse, 2001b). The participant mentors described how they welcomed students into the clinical area, introduced them to their colleagues, acting almost like gracious hosts in their efforts to make students welcome. As Chris indicates, it was then that mentors could facilitate student learning by providing access to learning opportunities for them. Lave and Wenger (1991) argue that it is the social situation, social practices and social relationships that create the possibilities for learning and access to what they describe as the 'community of practice'. It is mentors who seem to be providing this access. An early study by Hart and Rotem (1995) confirmed the social context of learning within nursing practice.

The mentors seemed to be trying to cultivate an atmosphere in which a dialogue between mentor and mentee can take place, as Emma describes,

> *'I always say to the students for them to ask me questions, so that I can get an idea of what they know and what they don't know. Em, and if they are not asking me questions then I start asking them questions, encouraging them to think for themselves, em and I quite often do reflective accounts at the end of the day, particularly if we haven't done very much em.. they can tell me positive points, good points and things that they want to do better. In that way, I can see what they are thinking so to speak, it's kind of a two way thing, just trying to be positive, make them feel wanted and needed and whatever they are learning is worthwhile'. Emma, interview 2, 59-67*

Here Emma is recounting the way in which she and the student look back on the day's activities. Emma seems to be encouraging the student to engage in reflective practice as a means of helping her to appreciate the tacit learning that has taken place. Emma also seems to be describing her techniques for gaining an understanding of what the student knows and what they do not. With an increased understanding of her student's learning needs, Emma can go on to set appropriate learning objectives to help her student move through their 'Zone of Proximal Development' (Vygotsky, 1986), helping the student to reach their full potential whilst on clinical placement.

From the data provided by Emma, it would seem that such an exchange could only take place where there is a high level of trust between mentor and mentee, as the mentee is encouraged to reveal areas in which their knowledge and skills are lacking. Therefore, the quality of the personal relationship between mentor and student appears key to creating a culture in which such a dialogue could take place (Pearcey and Elliot, 2004). Moseley et al. (2004), in devising a tool to evaluate the effectiveness of clinical placements, noted that key determinants of a 'good placement' were the personal characteristics of mentors and the quality of relationships. The mentors seemed to take a pride in cultivating a workplace deemed a 'good placement' by students and colleagues in the wider organisation.

The 'Standards of proficiency for pre-registration nurse education' (NMC, 2004) stipulate that there should be an equal division of time between studying theory and applying this knowledge in practice. The practice placement should be the ideal environment in which mentors can help students to relate theory to practice.

A placement in which social aspects of support are taken into account provides the backdrop against which mentors are able 'pass on' their skills and knowledge to students most effectively.

Establishing learning need

This subcategory emerged from the data as mentors debated the ways in which they established the learning needs of their mentees. Mentors needed to make decisions regarding appropriate skills and knowledge to 'pass on' to their students. The facilitation of this learning seemed to begin long before they met their allocated student as they pondered, 'what's this one going to be like?' Drawing upon previous experience, mentors seemed to have developed expectations of the characteristics and learning needs of students, making assumptions about students prior to meeting them. It was on this basis they seemed to pitch learning opportunities and pace learning at what they hoped would be an appropriate level, rather than making an observed assessment of student performance, as Betty illustrates,

> *'If you get a first year student where it's maybe their first or second placement they're sort of, they're like sponges, they just take in anything ...because they really want to see the basic nursing things rather.. you can't really take them to more complex things, because it's like running before they can walk'.* Betty, interview 1, 60-65

Betty seems to be assuming that all first years will be 'like sponges', motivated and keen to absorb a wide range of learning as they have experienced so little

previously, rather than doing a proper assessment of her student's capability prior to setting learning objectives. She appears to be admitting the complexity of determining the learning needs of students as she later goes on to discuss the difficulties in anticipating the requirements of more senior students,

> *'It's no good giving them things to do that they have done a lot of times that they know. It's trying to think of things, with the students, like what can we do to increase your knowledge and to increase your skills, and it's trying to identify that sometimes, well that can be demanding..... so it's trying to pin point what it is exactly that they need. So, I suppose that's why it's easier for first year students because they basically just need anything but the third years you have to be a bit more specific'.* Betty, interview 1, 70-79

The NMC (2008a) expects that mentors will use knowledge of students' stage of learning to select appropriate learning opportunities to meet individual needs. Betty has made some assumptions about students' learning needs to help her begin navigating this process. Adopting a stereotypical view in this way might be problematic as it could result in individual qualities or specific needs of a student being overlooked. For example, a junior student may have had many years of experience as a Health Care Support Worker. This attitude would also seem to contradict the person centred approach advocated by Rogers (2002). With senior students, Betty seems to indicate that a more individualised approach is necessary. This is the perspective adopted by Gloria as she describes how she identifies learning need,

'I try and establish at that initial interview what is expected of them, from their work book what their competencies are meant to be at that stage and what that actually means, and then identify key areas of learning that are specific to them and general areas of learning that are specific to their stage in their training'. Gloria, interview 1, 152-156

Gloria seems to be adopting a more personalised approach, using the student 'workbook' (student assessment documentation) to help her understand the specific learning requirements for the placement. She is using this assessment documentation as a guide to directly support the student to achieve the learning outcomes identified within it, tailored to meet the learning needs of her student. Later in another interview she describes this process in more detail,

'I get my student to write what they hope to achieve from this placement, sometimes I make a few notes, that gives them a bit of guidance as to what we can expect. If they have got the documentation from the last placement I like to read that because it gives a bit of insight into.. but they don't always have it, then it could be that day or it could be the next day that we commit our thoughts to paper, properly, neatly, as you might say, you know. And the objectives that I set with them are based on what they have achieved or what their last mentor has said about them but also has to focus on the fact that this is often their last placement or their second to last placement'. Gloria, interview 2, 57-65

Gloria seems to be describing a quite complex process in which potential learning is negotiated and boundaries set and is doing this in a more targeted way than the

'broad brush' approach Betty adopts with junior students. Gloria works in a clinic situation on a one to one basis with senior students over an extended period of time. She has to be confident that all student learning outcomes are met and that her student is proficient prior to 'signing off' for entry to the professional register. In contrast, Betty is describing her approach to newly recruited students. Neither Betty nor Gloria indicated that decisions regarding learning objectives are made on the observed assessment of students' performance. This is important, as it seems that at the start of placements mentors are setting learning objectives on student 'say so', rather than their own careful observation of students' clinical practice.

In the early stages of contact with their student the mentor is able to set out some ground rules regarding professional behaviour including appearance, punctuality and attendance. Student and mentor can then work towards clearly identified goals as a 'contract of learning' is tentatively established. Gloria uses regular formal meetings with her student to review progress,

> *'I find that really useful to remind us both what we are there for and to look back at what we have done and to see if we are actually going to achieve our goal at the end'.* *Gloria, interview 2, 83-85*

She provides insights into the way expectations of both mentor and student are explored in these early stages of the relationship. Evidence presented by Gloria and Betty seems to indicate that the mentor 'sets out her stall' as to the types of learning opportunities that might appropriately be offered, taking account of previous experiences of students at a similar stage. Learning outcomes for the clinical placement, identified in students' placement documentation, provide some

overall direction. The student's previous mentors feed into this process via written commentary. This is taken into account in helping to personalise learning objectives for the student. Parameters are set and a tentative agreement reached as to what might reasonably be achieved. According to these accounts, decisions regarding student learning requirements are made upon the basis of student 'say so' at the start of the placement.

Rowntree (1987) draws attention to the negotiation of objectives and the complexity of this process. He points out that that 'rarely, if ever, do objectives emanate solely from the desires of students or solely from those of others. Choice of objectives is a complex 'transaction' in which all parties concerned reach tacit agreement as to what is to count as valid educational knowledge' (Rowntree,1987, p.109). Rowntree suggests that the student is either a 'client' of an educational service or the 'product' of training. On such a continuum, the student's position seems determined by the extent to which they are able to have a voice in setting learning objectives, balanced by the need to achieve prescribed NMC proficiencies. These preliminary negotiations between mentor and mentee seem to indicate that the student is an active participant in negotiation of learning and that mentors are willing to be flexible in terms of the experiences they offer. Mentors seem to be adopting an approach that takes into account the principles of adult learning (Knowles, 1998). As the placement progresses the mentor is able to observe the student's practice and make an on-going evaluation of learning need. These early objectives may be reviewed and modified as a result to address specific deficits. These early discussions might be regarded as the first stage of a process in which mentors are trying to establish the 'inner boundary' of knowledge of the student. They seem to be trying to establish a baseline, a

starting point from which they can go on to extend student knowledge, helping them to achieve NMC proficiencies as they move through their Zone of Proximal Development (Vygotsky and Luria (1930), cited in Spouse, 1998a). In this way mentors can help students to learn and develop to meet their full potential.

'Showing them right'

Data presented within this subcategory emerged from the data as mentors expressed an awareness of themselves as role models to their students. This links to the category 'Passing it on' as mentors described how they wanted to 'pass on' appropriate professional behaviours and values to their students by example. The mentors seemed cognisant of students modelling their behaviours upon them. They had done likewise as students and appreciated the influence that role models had in clinical settings as Alex and Betty indicate,

> *'They are seeing it's alright for us to do it then.. it's all right for them'. Alex, interview 1, 216-217*

> *'... I remember how I saw mentors. You remember the ones that you thought 'Oh, I want to be like her'.....I think someone who related very well to the patient, and who managed to get things done'. Betty, interview 1, 291-296*

Betty seems to be echoing research by Davies (1993) who found that students focused on their role models' interactions with clients. Students in Davies's study

divided the values associated with practice that they witnessed into 'good' and 'bad' and were able to articulate those attributes of nurses which led to holistic care and those that led to impersonal, rigid care. Students say that good role models have a tremendous influence on the clinical learning environment and on the development of their skills and confidence. They expect to identify with someone whose behaviour and attitudes they can copy (Donaldson and Carter, 2005). Pearcey and Elliot (2004) noted that students' career aspirations were directly affected by their observations of trained nurses. Students felt that they also learned from the negative, in that when exposed to poor role models this made them aware of how they did not want to behave when they entered the nursing profession. This was a point made by Alex, in this current study, speaking about a student who had such an experience in a previous placement,

> *'It was the staff's attitude towards patients' families, she said they were so horrible, not to their faces but behind their backs and she just found it really upsetting and thought 'I don't want to be like this'.* *Alex, interview 1, 37-39*

Perry (2009, p. 36) describes role models as 'living lessons'. Bandura (1977) argues that most human behaviour is learned observationally through modelling. He states that this is much more than just imitative behaviour but is a major influence upon the observer's behaviour, in this case the student. Bandura suggests that people generally adopt the standards exhibited by exemplary models. The participants in this current study seemed aware of this as they mentored students, making efforts to 'show them right' as they coached student learning, as Fiona indicates,

'And when you have a student you really have to.. you are teaching them so you have to go 'by the book' you've got to say well, 'this is how it is done". Fiona, interview 1, 31-33.

However, Neary (2000b) argues that much of this role modelling occurs at a subconscious level as the qualified practitioner goes about her routine activities with the student also learning at a subconscious level as she works alongside the mentor. This is 'vicarious' learning, where learning is occurring without realisation that it is taking place. Perry (2009) argues that role modelling is an important means by which 'craft knowledge' is transmitted to students. 'Craft knowledge' being a body of knowledge that experienced practitioners have acquired over time based on practical, everyday experience (Spouse, 2001a). An expert nurse absorbs information from many sources when caring for her patient, taking account of subtle signs and symptoms, providing a complete picture of the patient's condition. For example, whilst changing a dressing she might notice a slight change in skin condition or that the patient is breathless. Such observational skills are not usually documented and could remain unshared. It can be difficult to 'pass on' but role modelling can provide a means of tapping in to this tacit knowledge. The importance of mentors working closely with their students is therefore critical in transmitting this knowledge. This could be impeded if staffing levels and skill mix are such that mentors are unable to spend sufficient time with their mentees.

'Speaking them through'

This subcategory 'Speaking them Through' emerged from the data as mentors described how they transmitted knowledge to their students. Data are presented of a range of strategies that mentors utilised across all four NMC domains of practice to support student learning. This subcategory links with the category 'Passing it on' as mentors provided data of how they 'passed on' their clinical skills, 'craft knowledge' and values to students and attempted to integrate learning from practice and academic experience. The mentors seemed to draw a distinction between 'coaching' and 'teaching'. 'Coaching' was described as the way in which they transmitted knowledge working side by side with their students going about their day to day activities together. By 'teaching' they seemed to refer to situations in which they held more 'formal' tutorials and attempted to convey 'book' knowledge to their students. The mentors provided data that seemed to demonstrate their use of a variety of approaches to support student learning. In adopting the role of 'coach' they seemed to be working alongside their mentees, demonstrating and then observing the student's performance in practice. Jacqueline describes how she coaches her student in attaining a clinical skill, speaking about it first, so that the student can be most receptive to the learning opportunity,

> *'So you have got it implemented in their heads really, before you actually do it and carry it out'. Jacqueline, interview 1, 295-296*

Cope et al. (2000) report similar findings where students are 'talked through' by their mentors, as they do a 'dry run' before letting students perform an authentic task. Brown et al. (1988, cited in Cope et al., 2000) have coined the term a

'cognitive apprenticeship'; this is a form of apprenticeship but one more sophisticated than that of 'sitting by Nellie'. The authors describe a range of strategies that the expert practitioner can utilise to support novices as they develop competence. These include modelling, coaching, scaffolding, fading, articulation and exploration. The mentors in this current study also used such strategies, as indicated by Irene and Gloria below,

> *'....take them to the patient's bedside and just try and speak them through it, of course get consent from your patient.... and then you can speak them through. And then the next time I would go with them, let them do it and you would observe'.* Irene, interview, 341-345

> *'...I explain to them that for the first part of their placement with me I am going to show them how to do things and then they are going to do it and then I'm going to watch them. And as our relationship develops they will be more and more independent of me and I'll sit back and they will run like, a diabetic clinic for me, with me in the background, doing the things that I need to do, ...and I'm in the room so that it is very much a case of to begin with I show them what to do and I talk as I go along and explain ..... Then after that they get their hands on and they do it, and I ask them why they are doing it that way'.* Gloria, interview 1,162-174

What appears to be happening in these situations is that the mentor is 'scaffolding' student performance, providing guidance and 'speaking them through', helping students to progress through their ZPD toward their maximum potential. In 'speaking them through' mentors seem to be providing examples of 'proleptic' instruction (Spouse, 1998a). At such times the mentor provides a guiding

commentary as a learner commences an undertaking they would be unable to achieve without help. As her student becomes more competent and confident, Gloria withdraws (fades) the support (scaffolding) so that more responsibility is transferred to her student as she moves towards proficiency. A study by Webb and Shakespeare (2008) reveals that students appreciated mentors who prepared them for new experiences and then, when they thought they were ready, stood by while students put what they had learned into practice. Van Eps et al. (2006) noted that assistance in gaining competence in psychomotor skills in this way contributed to self-confidence and overall professional growth. Atkins and Williams (1995) reported that mentors were not always comfortable with such a facilitative style. Gloria, above, however, seems to expect that her senior student will *'run a diabetic clinic'*, indicating that the student is making a valuable contribution to the work of the practice nurse, who is providing indirect supervision. This is important as Lave and Wenger (1991) stress that becoming proficient is largely dependent on being admitted to a community of practice, having a role and being able to function in the same way as the 'old timers'. Gloria's student is a novice but she is still able to make an 'authentic' contribution to the overall workload, termed 'legitimate peripheral participation' by Lave and Wenger (1991).

Data from diaries illustrated the wide range of strategies and resources the mentors seemed to employ to help students make links between theory and practice (see Appendix 18). They described directing students to an array of materials to support their learning, 'hard copy' and via the intranet. For example, they described encouraging students to read local and national guidelines relevant to their clinical experience. They reviewed case notes together and 'debriefed' students following critical incidents, encouraging them to reflect in order to gain

most from their clinical experiences. By such means mentors were able to support students explore and appreciate their practical experiences by drawing on formal, classroom knowledge.

The mentors spoke of 'teaching' their students by delivering 'mini tutorials' when time permitted as Gloria describes in her diary,

> *'I usually give a short tutorial on disease or treatment that we have either just seen or that features in general practice, e.g. B12 injections'.* Gloria, Diary

However, participants were reticent to associate themselves with the title 'teacher', a point also noted by Nicklin and Kenworthy (2000). Mentors regretted and apologised for not 'teaching' students more often, due to pressures of time. They viewed themselves as clinical coaches rather than 'teachers'. This is borne out in a study by Carlisle et al. (2009) who note that mentors rated 'supervising students undertaking clinical skills' as the most important aspect of their role. Cope et al. (2000) discuss the distinction that exists between 'knowing how' and 'knowing that'. They argue that experts operate by drawing upon experience gained as a result of complex situational understanding, rather than from 'higher-order knowledge' alone. The data discussed within the subcategory 'speaking them through' seems to indicate that for the mentors in this current study the emphasis was on developing students' practical skills. A range of strategies was employed to integrate practical experience with 'higher order' theoretical learning. Spouse (2001c, p.13) draws attention to the importance of this work-based learning and that it not a 'cheap option', requiring considerable time and resources if it is to be

done well. This has implications for workforce planning in considering staffing levels and an equitable skill mix.

Giving feedback

This subcategory emerged from the data as mentors described how they observed students in practice and then provided students with feedback, helping mentees to gain insights into their performance by 'passing on' their experience to the learner. The mentors described giving 'positive' feedback, in which student behaviour was reinforced and 'negative' feedback suggesting corrective action to be taken by the student. It seemed that mentors tried to deliver feedback in a constructive way, 'passing on' their own expertise to help students develop and building upon the learning objectives provisionally agreed at the start of the placement. However, providing 'negative' feedback seemed problematic for the mentors. They attested to the complexity of a situation in which they must exercise their professional judgement to protect the public whilst acknowledging the impact of their decision making at a personal level upon the students themselves. The mentors seemed aware that they are gatekeepers to the profession and are accountable for the decisions that they make in relation to feedback and formal assessment. All recognised that this aspect of the role was emphasised in the NMC (2008a) publication 'Standards to support learning and assessment in practice' but they expressed concerns about assessment generally and in particular when in the role of 'sign off' mentor. This corroborates the work of Middleton and Duffy (2009) who found that there were anxieties about being a 'sign off' mentor.

Here Emma provides an illustration of the dilemma that she feels is at the heart of assessing students' performance,

> *'But it is so subjective and I have brought this up at CLET [Clinical Learning Environment Team] meetings before and just because I think something is good somebody else might not think it is good. It is so subjective and it is difficult for the students. If people have said, yes they are fine, yes, no problems, then they come across somebody who is saying well actually it is not fine..*
>
> *Well, we are dealing with people and we are all different, so I just think that it is very difficult'.* Emma, interview 2, 192-199

Emma is expressing her concerns about the subjectivity at the centre of assessing another person, suggesting that the reliability and validity of decisions might be suspect. Students do have multiple assessments as they progress through their programmes, so weak students should be identified. However, the difficulties inherent in providing robust and fair assessment have been noted by a number of authors. Calman et al. (2002) draw attention to the wide range of assessment strategies employed by universities across Scotland and Watson et al. (2002) highlight the confusion that surrounds the definition of clinical competence. Fitzgerald et al. (2010) found that some students were not receiving the feedback that they needed and that there was much inconsistency identified in the feedback that was provided to students.

In my own study, mentors accepted their accountability in addressing issues of student behaviour or competence but discussed the difficulties they felt personally

in having to provide students with negative feedback, as Fiona illustrates with this diary entry,

> *'I felt really terrible about having a chat with X. I really wanted to encourage him but felt I was giving him negative feedback only. I know that we need to revisit the expectations we discussed at his first interview. I have to remember that it is my registration as well. I couldn't sign him off if he was underperforming but everyone deserves a second chance'.* Fiona, Diary

During 'second round' interviews, she returned to the topic of providing feedback to her student, something that seemed to concern her,

> *'...I mean it was something I had never had to do before, was speak to a student and tell them I wasn't too pleased with what they were doing and the things I was hearing back and fed back to me I didn't really think were very good and I didn't like it, I'd have to say. That would probably be my least favourite thing of being a mentor and I've always been quite lucky I've never had to do it so I didn't like having to do it, I didn't like how I felt. I felt pretty mean actually because I thought back to when I was a student and if somebody said something that I didn't like it really knocked your confidence, so I really went that we bit extra just to make sure that he knew that it wasn't a personal thing, it was constructive, to get him to pull his socks up a bit'.* Fiona, interview 2, 216-225

Fiona describes her apprehension in broaching aspects of performance with the student. A study by Carr et al. (2010) suggests that mentors might find it difficult to raise such issues as they fear that their skills will not be adequate to deal with a situation in which the student becomes angry, upset or disagrees with their assessment. Duffy's (2003) study also revealed mentors' lack of confidence and skills to address issues of failure. This being the case, it is not surprising that mentors feel apprehensive as Heather indicates when recollecting her dealings with a student several years previously,

> *'Yes, it was awful, it was awful. It was just that the student was just not interested; they weren't professional not even trying to be professional. They would rock up to work with no tights, scabby shoes, dresses that weren't ironed, hair out to here – as in I haven't combed it today, and 'glaekit' and when you asked them to do a job they just didn't do it. They needed to be failed but they were about half way into their course and nobody else had failed them, and we were working a night shift, so it was like her and me. So, it was quite difficult going to the school and they were 'Really?' because it was obvious she was quite a bright girl and they were quite shocked but yes, it was quite traumatic but I think it needed to be done and I regret it a wee bit but I don't regret it...'.* <u>*Heather, interview 2, 405-414*</u>

Heather seems to be coping with the difficult but not unusual issue of trying to shape a learner's personal behaviour when there are expectations of what should be the norm. She is alluding to the lack of support from earlier placement mentors, in their failure to address the student's unacceptable behaviour. Heather

also seems to have encountered lack of support from academic staff, in that they were sceptical of Heather's views, a factor that might deter a mentor from raising a 'cause for concern'. These findings corroborate those of Duffy (2003) where mentors described experiences with failing students as 'horrendous', 'traumatic' and 'exhausting'. The degree to which this took an emotional toll on mentors was evident. In this current study the data revealed the impact that dealing with a failing student had on mentors even when this had taken place many years previously. Carr et al. (2010) also noted that mentors revisited their experiences of dealing with failing students months after the event, recalling both professional and personal challenges.

Despite these challenges, participants reiterated their responsibilities in the assessment process, as Dora indicates,

> *'I think it's important to tell them where they go wrong and not just to let them carry on, I don't find that too easy because I don't like telling people off'.* *Dora, interview 1, 73-74*

In a subsequent interview she acknowledges her accountability,

> *'We can't just be passing them and hope that somebody else might pick up the problem'..* *Dora, interview 2,195-196*

The issue of assessment seemed to overshadow the relationship between mentor and mentee, even when the student was performing well. Emma describes how

she is aware that students feel that they are under constant scrutiny and how this can impact upon their behaviour,

> *'I think that some students are very aware that you are assessing them and you are signing them off, and they do put on this 'front', they try to be perfect as opposed to just being themselves ....but I am very aware that they are like little frightened mice sometimes (laughs)'. Emma, interview 2, 289-307*

Emma is indicating that students feel under pressure to put on a 'show' to impress her. This is not necessarily a bad thing if it indicates that knowledge of good practice exists. However, it seems that the impending final assessment blights her relationship with her student, Cahill (1996) also noted that students were pre-occupied with gaining a good 'ward report'. Herein lies the tension within the role and remit of the mentor much debated in the early nursing literature, for example, Anforth (1992). It is argued that the need to assess learners might impinge upon development of a positive working relationship between mentor and mentee, creating stress for learners due to fear of revealing weaknesses and fear of failure (Jarvis and Gibson, 1997). Students in Neary's (2000a) study indicated that they felt stress due to the assessment process. Nicklin and Kenworthy (2000, p. 107) argue that assessment can detract rather than enhance learning stating that, 'An assessment is a judgement made by someone about someone else, which of necessity invokes a hierarchical and authoritarian relationship between assessors and assessed'. This would appear to be a negative consequence of having the two roles combined within the remit of mentor. On the other hand, at some level individuals are always assessing others as this is a human trait helping us to

understand and relate appropriately to those with whom we come into contact. In the context of the professional mentor-mentee relationship the consequences of assessment are clearly more significant than such 'casual' assessments. Done well, continuous assessment can provide mentors with a means of helping students to develop. Students in a study by Gray and Smith (2000) valued the feedback given to them by 'good' mentors when this occurred. In any case, it is difficult to envision mentoring arrangements being organised differently by separating the roles. Professional guidance and advice can only be provided with on-going assessment of needs being undertaken by the mentor. Continuous assessment of students, providing on-going feedback in a constructive, positive manner is a way of supporting students to meet proficiency. Feedback is described by Rowntree (1987, p.24) as the 'life blood of learning' as it enables the student to identify strengths and weaknesses and to improve performance. The provision of timely and appropriate feedback to their students seemed often to challenge participant mentors as Irene here describes the dilemmas she faced in trying to deal with a poorly performing student in a sensitive way. Irene is being very thoughtful in what she feeds back to her student, so as not to overwhelm her with negative points,

> *'...there were lots of times when things were brought up and I did not want every single day for me to be nit picking, so I like, tried to make a point when there was something positive.. 'You did really well today, that was really good'... But I did everything that I thought was best... When I did my 'Facilitating Learning and Mentoring Module' that was always what they told us. It is the same with complaints, take people away from the situation into*

a quiet room, always start with something positive, say what you have got to say and end with something positive and I did try to do that'.

Irene, interview 2, 131-138

Irene seems to be drawing on knowledge gained from her mentor preparation programme to help her to deal with this situation. Clynes and Rafferty (2008) describe both formal and informal methods of delivering feedback to students that are available to mentors. They suggest that both methods are utilised to ensure that on-going and timely information is provided; participant mentors in this current study seemed to be doing so. 'On the spot comments' given as mentor and mentee work alongside each other have the advantage in that feedback is provided immediately and important elements are not forgotten. However, delivering feedback that was critical, as either part of formative or summative assessment, was challenging for mentors. Whilst all professed to understand their responsibilities in this respect, all seemed to have concerns regarding the personal consequences that could ensue for both parties.

Pride and Passion – Promoting the 'essence of nursing'

This subcategory links to the category 'Passing it on' and emerged from the data as mentors described how they passed on to students what I have termed the 'essence of nursing'. Within the subcategory 'Showing them right', mentors described how they attempted to be good role models to their students in demonstrating excellent clinical practice in terms of care delivery and management. In 'promoting the essence of nursing', mentors seemed to be fostering personal qualities in their students to help support this. Mentors

appeared to 'pass on' to their students an appreciation of the fundamental humanity involved in caring for another person, promoting an holistic approach and demonstrating kindness, compassion and sensitivity. Mentors seemed to be taking time to show students how to 'be with' patients, connecting with them on an individual level and motivating students to be 'the best that they can be'. For mentors this seemed to include satisfaction in being able to influence the profession in a positive way.

In recent times there has been an acknowledgement that essential aspects of nursing care, such as respect for the individual, have not been given the priority that they should. The NMC's (2009) 'Guidelines on the care of older people' and the RCN's (2008) 'Dignity Campaign' were attempts to refocus attention on these fundamentals of care. It was therefore reassuring to note that the mentors seemed to be fostering in their mentees a respect for the individual, as indicated by Fiona below,

> *'...But what I really want to pass on is that hunger, be the best that you can be, always strive to make a difference to somebody...em... even sitting with somebody with a cup of tea on a supervisory visit to see how they are getting on....you realise that there is a lot of lonely old people.. To me, passing that on to a student, o.k. it is a simple task of making a cup of tea and they sit down and yarn about everything and anything but in that half an hour you have given that person something they lack and that is human contact. And I mean the other thing that I always try to pass on is to take a pride in what you do, take a pride in helping people and you know, try to be the best that you can be, em.. you know, making it a positive experience'.*
>
> *Fiona, interview 2, 629-646*

Baillie et al. (2008) draw attention to the importance of taking the 'small things' seriously to promote dignity in care. Fiona seems to be providing her mentee with an example of how a 'small thing' can make a difference to the patient's quality of life. Making tea did not require highly advanced clinical skills. However, well developed communication skills are required in order to recognise need and then deliver care in a compassionate and sensitive way. The mentor can help develop these in a neophyte nurse in the way that care delivery is approached.

In another context, the mentors were keen that students saw the patient's whole situation regarding them as individuals rather than as an 'illness' or a 'condition',

> *'... but it is then trying to get them to see the bigger picture because you can get very... it can be very disillusioning you know, Mrs So and So's leg ulcer and Mr So and So's BM check and it becomes very task orientated, so it's trying to see the whole bit, who do they live with, who is looking after them, do they look after somebody or is there problems there?'* *Betty, interview 1, 129-134*

Betty seems to be describing how she encourages her student to adopt an holistic approach to care, seeing each patient as an individual, wary of regarding care delivery as a series of tasks. Later in the interview she elaborates this point,

> *'I'm happy as a mentor if I've passed on to students the.. the, you know... the whole... because I am a community nurse... the whole... so that they have a really good understanding of community nursing, all of the role of*

the community nurse and how we have to assess patients who are on the community. I think that I am happy when I have done that'.

Betty, interview 1, 266-270

The Francis Inquiry report into Mid-Staffordshire NHS Foundation Trust (Francis, 2010) and the Health Service Ombudsman's report (Abraham, 2011) provide examples of appalling standards of care. By contrast this study suggests that participant mentors are very sensitive to the value of holistic care and see the importance of instilling in their mentees attitudes that recognise the individuality of patients. The mentors provided insights into the ways in which they approached 'passing on' an essential quality of nursing in which kindness and compassion for the individual underpins all that we do.

'It is passing on the passion, passing on the skills, the knowledge that you have built up over the years of nursing, encouraging them... and you do feel alive when you have got a student because it makes you think and it makes you believe in what you are actually doing and passing that belief on and that passion'. Jacqueline, interview 2, 389-394

Participants spoke of the satisfaction that they felt in being able to hand on their skills and expertise to their students,

'I think you get a great sense of fulfilment, by passing on your knowledge and your experience...' Gloria, interview 1, 21

Chris, in the extract below, seemed to epitomise what it was that mentors were trying to convey to their students,

> *'It just sounds really old fashioned but I am proud of the NHS, I want them to feel proud of something they can work for...'.* Chris, interview 2, 222-223

Summary of the Category 'Passing it on'

The category 'Passing it on' encapsulates the many ways in which participant mentors pass on to students their clinical skills and expertise across the four domains of practice identified by the NMC (2004). We glimpse the complexity involved in developing appropriate knowledge, skills and attitudes in novice practitioners. The mentors bear witness to the range of ways in which this complex exchange of information takes place as they strive to 'pass on' a legacy of excellence in nursing practice. The mentors contribute to a clinical environment in which learning can occur by helping students to feel at ease and provide them with appropriate learning opportunities by which they can make a valued contribution. They negotiate learning objectives with their mentees, tentatively agreed in the first instance and then developed as the mentor provides on-going feedback, directing their support in a bespoke way for each student. This is an aspect of the mentor role that many find problematic. 'Passing on' knowledge and expertise occurs in a myriad of ways as mentors attempt to integrate learning from practical and academic experience, for example, by acting as role models, 'coaching' their students, 'scaffolding' learning and providing access to specific and legitimate activities. Underpinning all of this is the way in which mentors attempt to develop professional and ethical practice in their students. Mentors seem to derive

satisfaction and take a pride in the fact that they have the opportunity to pass on their skills to the next generation of nurses, 'repaying' those who supported them in the past.

'A surrogate family'

This category presents student experience on clinical placement as analogous to aspects of family life. What emerged from the data was that participant mentors seemed to engage in caring relationships akin to those found in a nurturing family. They described themselves and colleagues as a 'surrogate family' for students. The mentors seemed to take into account the fact that students are often far removed from their own families and usual networks of support when on placement with them. Against this backdrop, this category describes relationships that develop between the mentee, mentor and the wider clinical team. Data are presented of how students are admitted into the 'family of learning'. Family life can provide a nurturing environment in which young members can develop to their full potential. Participant mentors seemed to be describing how they fostered an environment in which student learning can flourish. However, family life is also complicated and messy and family dynamics can be volatile, easily disrupted by the arrival of a newcomer. Anguish can result for mentors, mentees and the wider clinical team when effective relationships are not well established or maintained. This category 'A surrogate family' captures the pastoral dimension of the role of mentor. It links to the following subcategories,

- 'A mother and her child'
- 'Sussing them out'
- A new family member

'A Mother and Her Child'

During interviews mentors often drew upon imagery of mothering to describe the relationship with their mentees, this 'maternal' imagery pervades all of the subcategories within this category. Its use was not confined to those mentors who were mothers. Even those who did not associate themselves with a mothering role described themselves as 'guardians' to their students. The element 'A mother and her child' is included within the category of 'A surrogate family' because mentors described their relationship with their students in terms of a close family bond. The following quotation provides an illustration of this,

> *'Yes, it's a one to one relationship - like a mother with their first child, it's full on'.* *Gloria, interview 1, 107-108*

Those who were mothers drew upon experiences derived from their own children, to offer an explanation of how they approached their mentees,

> *'... you worry about them, and I think that comes because as a parent ourselves... we know our children have got to go away and I think that's how we would like our children treated – so I think that's where it comes from really, just replacing – well, if that was my kid, I'd want them to be looked after that way'.* *Jacqueline, interview 1, 195-201*

Jacqueline seems to be suggesting that for mentors whose own children have left the island, mentees provide a 'substitute'. The mentors often drew parallels between relationships with their own children and those with their students,

'I think that you have got to get it right, I know that some mentors are very maternalistic and I always try and remember what I felt like at that age, and sometimes you want it and sometimes you don't so I try and keep it so that it is... I know that some mentors have their students round for tea and things like that. If I had a student that I really felt needed that then I would do it but mostly I think that you have to... it's like your own children you try not to suffocate them'. Gloria, interview 2, 232-237

Gloria seems to be indicating that the relationship must be cultivated very carefully. Later she goes on to describe how she draws upon her experience as a mother to guide her approach in giving feedback to her student,

'...I think as a parent with grown up children you learn to tell people when they are not doing something well or right, and not let it influence how you are with them for the rest of the time, now having said all of that, this is not your children, they are not your family, they don't love you and you don't love them'. Gloria, interview 2, 249-253

Whilst mentors made comparisons to relationships with their own children, Gloria makes an important distinction. The mentor-mentee relationship is set in a professional context, distinguished by professional boundaries. Mentors do not love their mentees. However, Campbell (1984) describes the relationship between professional helpers and their patients in terms of a 'moderated love' and his arguments bear comparison with mentor-mentee relationships explored in this current study. Campbell suggests that professional care is a form of love because it entails a personal commitment by the person offering the care which cannot be

captured in the language of a contract. He argues that it is only when we view professional care as a form of moderated love that we can appreciate its special character. The mentors seem to be indicating that they too have a special relationship with their mentees, expressed as a form of 'moderated love', which cannot be fully captured in terms of a contract of learning. Campbell also draws upon the image of nurse as 'mother' to her patients in a way that resonates with mentor as 'mother' to her students. However, he urges caution in that such a mothering relationship can only be beneficial if it promotes growth. A domineering mother can hold back development. Campbell (1984, p.42) states that there should be a 'consistent effort to promote independence and self-maintenance'. In the early literature on mentoring, Darling (1985) drew attention to 'toxic' mentors. Such mentors could inhibit student development by a variety of means. For example, Darling described them as 'Blockers' who did not meet students' needs, often as the result of too close supervision. A mentor adopting an 'over protective' mothering role might fall into this category.

Within the mentoring literature a body of evidence has built up identifying the importance of the personal relationship between mentor and mentee. Webb and Shakespeare (2008) provide interesting insights into the emotional labour that goes into establishing a good relationship between mentor and student. They focus on the extent to which students must expend emotional labour in order to develop satisfying relationships with their mentors. My findings would suggest that mentors also invest considerable emotional labour in sustaining the relationship as they view their mentees in terms of an 'attenuated' mother-child bond. Smith and Gray (2001) also identified mentors as the key providers of emotional labour and support, referring to the work of Hochschild (1983). The flight attendants in

Hochschild's study described emotional labour as the ability to sustain an outward appearance that produces in others a sense of being cared for. It would seem that mentors in this current study aim to do this by adopting a 'mothering' persona and displaying a moderated love to their mentees. There are risks for mentors in adopting such an approach. They appear to invest in their students at a personal and emotional level to make their students feel cared for and supported. At the same time, they must always maintain a professional relationship that enables them to provide appropriate feedback and assessment of student performance. This is sometimes a difficult balance to achieve. McKinley (2004, p. 205) asks, 'How often has it been said that nurses eat their young?' and this perhaps is what happens when mentors are operating at the other extreme, being harsh in their criticism of their mentees.

'Sussing Them Out'

The development of this subcategory emerged from the data as mentors seemed to be demonstrating attempts to gain a more holistic understanding of their students. The participant mentors appeared to seek insight into their students' lives, cognisant that attending a remote placement could pose added challenges to students. Such challenges had the potential to impinge upon student learning and mentors seemed keen to gain a broader understanding of their student's lives to help better support their learning. The mentors seemed to appreciate that often students were removed from usual support networks and sought means of filling this void, as Emma indicates,

> *'....but I do try and find out a little bit about the student's kind of personal history and a bit about their background because we are all different, we all*

have our own 'baggage' so if you can understand a bit of what's going on in their life it is kind of easier to help them, you know...'.Emma, interview 2, 87-90

The participant mentors seemed to realise that in order to do this they needed to establish a personal relationship at this very personal level, so that students would feel able to speak freely to them, as Alex describes,

'So I think we need to be almost a surrogate family to them, encourage them to come to us if there is anything that they are worried about or know that they can come to you to speak to you about anything...'.Alex, interview 1, 71-74

Much evidence exists within the nursing literature relating to the importance of the personal relationship that is established between mentor and mentee, this being central to the success of the mentoring (Spouse, 1998b). The personal qualities of the mentor are a significant determinant of success (Moseley et al., 2004). Alex seems to be acknowledging the vulnerability of students removed from usual support networks. The participant mentors spoke of students being young and often away from home for the first time. They seemed to recognise that for some students such a remote placement could exacerbate existing problems. For example, the mentors raised such issues as student debt being compounded as students had to relinquish part time employment to attend placement. Some students had family responsibilities that were neglected whilst on placement and homesickness was a cause of much unhappiness. Mentors recognised these and other issues as having the potential to impact negatively upon students' clinical performance.

The mentors needed to be perceptive and use a range of communication skills in order to fully appreciate the complexity of students' lives, as Dora describes below,

> *'Well, I think that you have to be able to really suss them out, em.. this last student I had, she seemed to be wanting to go home a lot, and in the end, it seemed that this girl's brother had been taking drugs and I think underneath it was troubling her, and sometimes we would have a wee heart to heart and she would say, 'Oh, I'm just a wee bit worried about my brother'..... and then she opened up to me, she told me that that this was what her brother was doing'.* Dora, interview 2, 263-270

The mentors seemed to understand and empathise with students having much to contend with, as they had to adjust to changes in their living conditions as well as address the challenges of a new clinical environment. The mentors seemed to take account of this, as Jacqueline implies below,

> *'You take an interest not just in their working environment but their social, I suppose temporary home environment as well, em... you know and if they are unhappy because the home they are staying in is...., the room is cold, or it's draughty, the cooker isn't working or anything, we have to take that on board and help them to sort it out'.* Jacqueline, interview 1, 191-195

Jacqueline seems to be acknowledging that factors outside the workplace could impact negatively on her student's ability to learn. She elaborates this point in a later interview,

'That can seem an awful long time to them [15 weeks on placement], and if they get lonely, you know consequences can happen, they get depressed and this and that can have an impact on them, their health and how they work and sickness and stuff. So I think they... yeah, they do need a bit of mothering sometimes'. *Jacqueline, interview 2, 172-175*

This was noted by Atkins and Williams (1995), where mentors spoke of their concern for mentees, not just as nursing students but as individuals. Young students, recently moved away from home and struggling with debt were some issues raised by mentors as issues of concern. The parallels with my own study were striking. Supporting students in such situations was emotionally demanding for mentors. Duffy (2003) noted that mentors took account of student's personal circumstances in the context of making decisions about their performance.

The literature provides examples of the high levels of anxiety experienced by students on clinical placement. Gray and Smith (1999), Phillips et al. (2000) and Higginson (2006) have identified a range of fears and worries experienced by pre-registration nursing students. It is likely that these feelings are magnified when students are removed to a distant location, having to deal with the challenges presented by a new social as well as professional environment. Mentors seem to be taking this into account in the way they provide 'pastoral' support to students. To do this effectively they must establish a good personal relationship with their students, as Heather indicates,

'We try and make sure that they have got that personal backup as opposed to professional back up...' *Heather, interview 2, 243-244*

Here Heather seems to be indicating her perception of the role as including a personal as well as professional element. In this subcategory mentors seemed to be demonstrating an approach that sought to 'tease out' from students any issues or concerns beyond the professional domain, so that they could better understand and consequently better support their students.

A New Family member

This subcategory emerged as participant mentors provided data regarding the impact that the arrival of a student could have. This could change the dynamics of established relationships very markedly in very small teams. Furthermore, mentors seemed aware that students needed to be orientated to the wider community, outside of the professional setting. There seemed to be a recognition that students had to feel comfortable in their whole environment in order to feel at ease in the workplace. All of the mentors spoke of the importance of helping students to feel accepted so that they could perform at their best. They described a variety of ways in which they go about making the student feel 'at home'. This included introducing them to other members of the team, helping them to have a 'voice' and including them in social activities.

Here Fiona describes how her team approach students as 'one of them' in an effort to make the students feel 'at home' and giving an insight into how they help the student to orientate to their new wider environment,

'...I suppose we just make sure that they are all right.... Things like, do they know where the shops are and if they don't have a car we go and fetch them, and then take them to the shops just... If there is anything going on of an evening socially ...that we think might interest them, we tell them about that, if we are going to X town, say one of us is going to X town on a day off, and the student was thinking to go, we would give them a lift down, you know... I mean we just, I suppose we just kind of treat them the way we kind of treat ourselves...'.Fiona, interview 1, 378-385

The mentors seem to be befriending their students; this was considered a significant factor contributing to success in the mentor-mentee relationship by students in a study by Chow and Suen (2001). On very small islands, the mentors saw this as an important part of their role. Tiny communities were very quick to note the addition of a new student nurse to the community nursing team. It seems that mentors considered it important that students should be welcomed to island life and integrated into the wider island community too. All the mentors mentioned social activities to which students were invited as part this integration process, reinforcing a sense of belonging, as Alex indicates below,

'Try to involve them and if there is anything going on socially we would always try and involve them and usually chip in so that they don't have to pay for their meals, I mean sometimes you build up a really good rapport with your student and have them home for their tea'. Alex, interview 1,162-166

By including students in social events and activities it seems that mentors are conveying a powerful message of acceptance to their students. In his classic work 'Motivation and Personality' Maslow (cited in Banyard and Hayes, 1994) proposed that there is a hierarchy of needs. These ascend from basic biological needs to more complex psychological motivations. According to Maslow 'belongingness and love needs' must be met before an individual can progress to fulfil higher level needs. According to Maslow's theory, mentors must engender a sense of belonging in their students so that they can progress to meet their higher level cognitive needs. The findings of a study by Levett-Jones and Lathlean (2008, p.103) suggest that 'belonging is a prerequisite for clinical learning'. They describe belongingness as a response to which an individual feels,

- secure, accepted, included, valued and respected by a defined group
- connected with or integral to the group
- that their professional and/ or personal values are in harmony with those of the group

The mentors in this study seem to be demonstrating an awareness of this as they make attempts to create an environment that fosters a sense of 'belonging' in their students. Chris describes how students are helped to feel that their views are valued and respected, aligned to those of the group,

> *'If you are meeting with doctors, when say they are discussing a patient, you can always say to a student, 'Oh yes, you were with them last week how did you find Mr Gray?', or whoever and they can chip in'. Chris, interview 2, 69-71*

In the workplace the mentors seemed to understand that new students could feel awkward and unfamiliar with ways of working, including them in a social sense was important but as Chris illustrates above, mentors had a vital role in providing students with opportunities to make a meaningful contribution, so that their learning could fully develop. This is legitimate peripheral participation as described by Lave and Wenger (1991). For newcomers this is at the periphery of the core work, important but not always essential to it. The mentors were able to provide opportunities so that students could make a valued and authentic contribution to care delivery, as Alex describes below,

> *'...and sometimes you find them sort of taking a step back, you say to them, 'Well- you could put on the blood pressure cuff and get this for us and they do and they get stuck in and then they are fine'.* Alex, interview 2, 187-189

Domain one (NMC, 2008a) states that mentors should demonstrate an understanding of factors that influence how students integrate into practice settings. The data and discussion presented here seems to indicate that the mentors are aware of the importance of helping students to integrate into the team. As well as integration to the practice setting, participant mentors seem to understand that integration to the wider community is important in small, remote settings so that students can feel comfortable with their whole experience as they begin to address their learning needs.

Summary of the Theme 'A surrogate family'

The data and discussion presented within the theme 'A surrogate family' suggests that mentors supporting students in remote placements have a heightened pastoral element to their role. The mentors describe the relationship with their students in terms of a close family bond, likened to a mother and child, expressed as a 'moderated love'. The mentors are aware that students often have complex lives and that personal problems can be exacerbated when removed from usual networks of support. The personal relationship between mentor and mentee has been identified as being fundamental to the success of the mentoring relationship but in these more remote placement settings this seems to take on even more significance. In addition to helping students integrate into the practice setting, the mentors must help students to adjust to their new social situation.

Fostering Student Learning

The categories and subcategories that I have presented in this Chapter have been unified within a central category that I have termed 'Fostering Student Learning'. According to Strauss and Corbin (1998, p.146) a central category has the power to pull together all the other categories to form an explanatory whole, encapsulating 'what this research is all about'. 'Fostering Student Learning' seems to be able to explain the mentors' experiences and behaviours as they facilitate students' learning and development in a remote and rural setting. The remote context seemed to bring an added dimension to the mentor role requiring participants to enhance the pastoral element of support for students. Commitment to supporting students appeared not to be confined to the professional domain, rather it

extended to the personal arena as participants demonstrated an awareness that students were often far removed from usual networks of support.

In taking on the mentor role and 'Having a student', participants seemed to be fulfilling an expectation that mentoring was part of what they did, intrinsic to their role as registered nurses. In this sense 'choice' as to whether they took on the role was side lined. Their commitment to it was embedded into their nursing persona. Consequently, even as participants acknowledged that mentoring a student carried with it increased responsibility, all expressed a desire to continue their commitment to it. There was recognition that a power dynamic existed between mentor and mentee. The participants seemed to understand that to 'Foster student learning' the quality of the relationship with mentees was of paramount significance. The participants in this study demonstrated efforts to create an atmosphere in which skills and knowledge could be passed to the next generation of nurses. The mentors saw themselves as role models and 'coaches' and were keen to pass on appropriate personal and professional attitudes to their mentees. Passing on pride and passion was seen as key to their role as mentors. In a remote setting 'Fostering student learning' presented unique challenges for participant mentors. Appreciating that in such a context students were removed from usual networks of support, the mentors and wider clinical team seemed to fill this void by acting as a 'surrogate family'.

5. Fostering Student learning

This project set out to increase understanding of the experiences of mentors supporting pre-registration nursing students. What has emerged from analysis of the data is a tentative theory of how mentors 'Foster Student Learning' in remote and rural placements. In this chapter I explain this tentative theory and how the key themes emerged to lead towards its development. I consider what it has to offer in answering my research question and sub-questions regarding the role that mentors play in facilitating learning in practice. I go on to make recommendations for future practice in the way that mentors are supported in their role.

A tentative theory: 'Fostering student learning'

The 'role specification' for mentors and 'sign off' mentors is to be found clearly set out in the document 'Standards to support learning and assessment in practice' (NMC, 2008a). However, the stark lists and tables to be found therein belie the complexities of actually carrying out such a multi-faceted role. This research project revealed that student learning in clinical practice seems to hinge upon a complicated fusion of both social and cognitive experiences. What emerged from analysis of the data is that the mentor role appears of paramount importance in providing access to both. In addition, mentoring in remote settings seems to add another dimension to the role as mentors extend the pastoral element of what they do to help students acclimatise to their new environments both inside and outside the workplace. That mentors 'nurture' their students emerged as a key aspect of supporting students in a remote setting.

The tentative theory 'Fostering student learning' is put forward to explain the role that mentors play in facilitating learning in practice, and their motivations for doing so. The Concise Oxford Dictionary (1982) defines 'foster' as both an adjective and a verb. As an adjective, 'foster' is described as 'having a specified relationship not by blood, but in virtue of nursing or bringing up'. As a verb, 'foster' is defined in terms such as 'promote growth of', 'encourage', 'tend affectionately' and 'cherish'. 'Fostering student learning' therefore seems appropriate as a term to represent my findings, in which student learning seemed to be nurtured, in an atmosphere likened to a supportive family. 'Fostering student learning', as a tentative theory, emerged from the data as a way of viewing how the relationship between mentor and mentee is played out in remote locations. It is defined as the way in which mentors demonstrate commitment to a role in which they pass on their skills, knowledge and professional attitudes. This overarching theory comprises three themes, 'Having a student', 'Passing it on' and 'A surrogate family', capturing the complexity involved in supporting a student. I now discuss how the themes emerged from the data.

'Having a student'

Mentors frequently spoke of 'Having a student' as an abbreviated way of capturing the mentor-mentee relationship. By 'Having a student' mentors were carrying out an element of their role apparently considered by them to be intrinsic to it but acknowledged as complex and difficult. This evolved as a core category as analysis of the data revealed links to subcategories that helped to explain the complex dynamics involved in such an association. 'Having a student' was a

'short hand', casual way mentors used to describe a complex relationship. This was common parlance that I, as an 'insider' researcher with knowledge of mentorship, immediately comprehended. In my efforts to 'make the familiar strange' I wondered what it was that this 'throw away' term actually meant to the participant mentors. This led me to review the data in a purposeful way, looking for links between the subcategories that might help to explain what 'Having a student' meant to participants. It seemed that mentors regarded 'Having a student' as part of their role and expected it to be incorporated into their day to day activity. In this respect it was regarded in a rather 'nonchalant' way but mentors also acknowledged its importance, requiring personal commitment to perform it well. The participants acknowledged the responsibility that came with 'Having a student'. Despite this they seemed to consider it worthwhile in that it could bring many benefits both professionally and personally. In short, the participants seemed to feel strongly that whilst 'Having a student' was part of their 'day to day' work it was very significant as mentoring seemed to enhance their own professional and personal lives.

The mentors seemed to be saying that 'Having a student' was part of their role, embedded in what they did. The comments of Betty (Chapter 4, p. 95) and Chris (Chapter 4, p. 96) were very typical in this respect. This was not unexpected as both 'The Code, Standards of conduct, performance and ethics for nurses and midwives' (NMC, 2008b) and 'Standards to support learning and assessment in practice' (NMC, 2008a) require that all registered nurses will facilitate students to develop competence. What seemed important to participants was not the formal role or title, just a very strong belief that this was what they had to do to the best of their ability. Some participants could pinpoint the start of formal mentoring careers

to a mentor preparation programme but for most it was what they had 'always done' and as such was just 'part and parcel of nursing'. 'Choice' as a property of the category 'Having a student' seemed minimised in two respects. First, there was an underlying organisational expectation that registered nurses would take on the formal role and second, it was what participants did as a matter of course as it was rooted within their nursing persona. It seemed that whilst mentors were aware of NMC expectations of the role, the 'vision of excellence' in mentorship seemed to spring from a much more personal source.

The mentors demonstrated personal commitment to undertaking the role, sometimes providing support to students 'in their own time' and going beyond the call of duty to support their students. 'Commitment' emerged as a subcategory as mentors described how they went about their mentoring duties, engaging with students and often 'putting themselves out' to support their students in making the mentor-mentee relationship a success. Some said that they felt 'guilty' because demands of their job meant that they could not always perform as effectively in the mentor role as they would have liked. This might help to explain why mentors were willing to give up their own personal time, as they sought to compensate during 'off duty' hours for the time they could not spare for their students when on duty. Analysis revealed that all mentors spoke about their commitment and provided examples of how this was demonstrated. Giving up their own personal time, making themselves available to students by providing home contact details and attending mentor update sessions on days off were some of the ways in which the data seemed to demonstrate this. This linked with the finding that mentors considered supporting students as integral to their role. As mentoring seemed to be perceived as a key element of their professional lives they appeared willing to

expend considerable personal resources in doing it well. What emerged was a sense that when the mentor-mentee relationship was well established there was a synergy, in that the mentor, as well as the student, was gaining from the association. The categories 'It's good for us' and 'The feel good factor' capture aspects of what emerged from the data as mentors described the benefits that accrued to them both professionally and personally in 'Having a student'. They recognised students as a learning resource and a means of driving themselves on to ensure that their own practice was evidence based. This seemed of particular significance to the participants, cognisant that they practised in a remote setting, as they were keen to ensure that their practice was current. Comments such as those from Fiona (Chapter 4, p. 122) were typical, in that mentors wanted to show their students 'by the book'.

The mentors also seemed to see within their role a means of influencing the future of nursing and this appeared important to them at this personal level. This commitment and sense of satisfaction to be gained from supporting students helped them to rise to meet the many challenges they faced. This linked to the subcategory 'A big responsibility' that emerged as the data revealed the challenges involved in supporting students and how mentors went about addressing them. Irene's comments (Chapter 4, pp. 106-107) were representative in the way that participants described how they felt under constant pressures of time and under the scrutiny of their students. Participants seemed to make valiant efforts to juggle workloads so that they could simultaneously support students and manage patient care without compromising either. That student support was maintained at a high level seemed to hinge on mentors' personal commitment to the role and mentors' willingness to provide some of that support in their 'own'

time. The category 'A big responsibility' emerged from the data as mentors articulated what they had taken on by 'Having a student'. Overcoming the challenges of supporting students appeared to enhance mentor satisfaction in a job well done and enhance their self-esteem. A sense of self belief in one's ability to perform well in a role is very important, according to Bandura (1986) it largely determines the effort that will be expended upon a task.

This data, relating to what 'Having a student' meant to mentors, seemed to begin to provide some answers to my research question, 'How do mentors see their role in promoting students' professional development on clinical placement?' The participants appeared to be committed professionals, who saw themselves as having an important role to play in enhancing and promoting the profession by the way in which they supported students.

'Passing it on'

The mentors spoke with passion about how they were committed to the role at a very personal level as I have described above. What emerged from the data was that this commitment was largely driven by the desire to 'Pass on' their skills and knowledge. This became another key theme contributing to the tentative theory of 'Fostering student learning'. 'Passing it on' was an expression used frequently by mentors. It seemed to me a rather 'colloquial' term for how the mentors were supporting students in gaining competence across the domains described by the NMC (2004). What mentors seemed to be saying was that they wanted to 'pass on' clinical skills and knowledge regarding care delivery and care management and they described a myriad of ways in which they did this. What emerged was

that it was not just practical skills that they wished to 'pass on'. Indeed, the data revealed that it was a pride in the profession that seemed to be the bedrock upon which mentors could foster appropriate professional attitudes and ethical practice within their mentees. I explored the data for links that existed between subcategories that might help me to understand the complexity of what it was that mentors 'passed on' to their mentees, how and why they did so. The participants seemed to understand that 'Passing it on' would occur most effectively if they established a supportive atmosphere within the clinical placement in which learning could thrive. This, it seemed, was what they considered to be the essence of 'A good placement'. In a supportive atmosphere students could be provided with a role in which to contribute to care delivery. The mentor seemed the lynchpin in providing this access to an 'authentic' role for their mentees. The whole process of 'Passing it on' seemed driven by a pride and passion in the profession that mentors sought to convey to their students.

A quite intricate picture emerged in which mentors sought to establish, by a process of tentative negotiation in the early days of the mentoring relationship, what it was their mentees needed to learn. 'Establishing learning need' emerged from the data as a category as mentors described how they tried to establish a base line with their students upon which they could build their learning. This done, mentors could set about transmitting skills and knowledge as required. As the mentor-mentee relationship developed it seemed that mentors tailored their support to meet their students' needs more specifically. They used strategies such as 'role modelling' and 'coaching' to demonstrate best practice to their mentees and engaged in reflective activities to help their students appreciate key learning gained in practice. The mentors seemed to distance themselves from a

more formal 'teaching' role, though they seemed to regard 'teaching' as more 'worthy' and important than what they were doing in their day to day interactions with students. I noted that the mentors sometimes apologised for not having sufficient time to 'teach' students more formally. The mentors described 'showing them right', apparently cognisant of the impact that their example could have on their mentees as they sought to pass on their knowledge, skills and professional values.

'Use of self' in this way appeared to be a significant means utilised by mentors in supporting student learning in clinical practice. It seemed that mentors understood the profound impact that their actions could have on students, aware that the example they set could mould students' professional and personal behaviours and that this might take place at a subliminal level. To pass on skills in care delivery and management, mentors adopted the role of 'coach', working side by side with their students. In such a way they were able to 'pass on' what Spouse (2001a) terms 'craft knowledge', relating to the knowledge that experienced practitioners have attained over time, derived from practical, everyday experience. As coaches, mentors employed strategies described by Vygotsky (1986), such as 'scaffolding' and 'fading' to help students undertake tasks they would otherwise be unable to undertake on their own. This was what mentors described as 'Speaking them through', a strategy utilised to pass on their skills and 'craft knowledge', integrating learning from practice and academic experience as they did so.

An important means of 'passing on' their expertise and knowledge was to provide feedback to students, both formatively and summatively, to guide their students'

learning and development. This subcategory linked closely with those of 'Showing them right' and 'Speaking them through' as mentors provided feedback on an on-going basis whilst demonstrating their clinical skills and conveying their 'craft knowledge'. The process of assessing students and providing timely and appropriate feedback was an important means of 'Passing it on' and guiding their students. However, providing 'negative feedback' and challenging inappropriate student behaviour seemed very problematic for mentors, the comments of Fiona epitomising their dilemmas (Chapter 4, p. 130). What emerged was that mentors fully understood their accountability in this respect but also that dealing with a poorly performing student took a heavy emotional toll upon them and was something they felt unsure of and unhappy to tackle.

Underpinning all of the subcategories within this theme was a desire to 'pass on' to students a pride in the National Health Service and a passion for the profession. 'Pride and passion' linked with all of the subcategories as mentors seemed to be instilling into their student not only appropriate professional behaviours but encouraging in their students an appreciation of the essential humanity involved in caring for another person. The data encapsulated within the category 'Passing it on' went some way to help address my research question, 'How do mentors support students across the 4 domains identified by the NMC (2004)?' What emerged from the data was that mentors conveyed their skills and knowledge to students in a variety of ways, all underpinned by a desire to instil in their students a pride in the profession and 'doing their best'.

A 'surrogate family'

The theme 'A surrogate family' emerged from the data as analysis revealed the way in which mentors seemed to view themselves as 'nurturing' their students. In my first interview, Alex used the term 'A surrogate family' (Chapter 4, p. 144), indicating that mentors, and the wider team, acted as a proxy family for students far removed from their usual networks of support. I noted this as being a particularly striking analogy and as I compared interview with interview noted that terminology surrounding family life and relationships with children was used frequently by mentors, the comments of Gloria (Chapter 4, p. 141) being representative. I pondered what this meant in terms of mentoring and what the dimensions of such an element might be. In second interviews I explored this in more detail with mentors, the subcategories of 'a mother and her child', 'sussing them out' and 'a new member of the family' emerged in helping to explain the way that mentors nurtured and 'fostered' their students' learning. That mentors saw themselves in a 'mothering role' or that of a 'guardian' was not surprising. Many were mothers themselves and drew upon their own experiences with their children, in the way in which they related to their often younger mentees, as Gloria describes (Chapter 4, p. 141). The mentors described how they gained satisfaction in seeing their students grow and develop under their guidance; this seemed a powerful motivation for them in undertaking and continuing the mentor role. This mothering and 'nurturing' aspect of the mentor-mentee relationship presented as an important element of the mentor-student dynamic. Linked to this was the idea that in order to fully support their students, the mentors seemed to be trying to gain insights into their students' personal lives, aware that such matters might influence

their performance in the clinical setting. The subcategory 'Sussing them out' derived from the many examples the data provided of how mentors sought to gain a deeper understanding of their students. This seemed a particularly important element in how mentors supported their students in remote settings. The participants seemed aware that issues might arise that were unlikely to crop up in more urban or mainland settings where students might remain in their social groups and usual place of residence whilst on clinical placement. For example, homesickness, dealing with family responsibilities from a distance, settling in to temporary accommodation could all be problematic for students. They seemed to be adopting strategies to help students integrate into their communities both inside and outside the clinical environment, providing a 'safety net' so that their students can gain confidence. I do not mean to suggest by this that the mentors' role in mainland or urban settings is any way less significant. Full acknowledgement is given to the fact that mentors in such settings have a vital role in how students are supported in a personal sense, as identified by Gray and Smith (2000). My findings indicate that their counterparts in more remote placements are presented with additional challenges as a consequence of location. This linked to the subcategory of 'A new family member' in which mentors were describing how they welcomed students, not only to the clinical placement but to the wider setting of their new living environment, helping them to integrate into the wider community. Now I will consider how the insights gained from the study, as summarised above, have enabled me to address the research questions identified during the initial stages of the study.

What role do mentors play in facilitating learning in practice?

I now discuss the tentative theory 'Fostering student learning' considering what it might contribute to addressing my research question, 'What role do mentors play in facilitating learning in practice'. 'Fostering student learning' is put forward as a theory, grounded in the data, as a way of viewing how mentors support students in practice. I acknowledge the challenges and pitfalls in attempting to build theory from data generated from a very small sample of mentors. The mentors were only 10 in number and all volunteered to take part in the study. There were no newly qualified mentors in the study, their perspective and that of students is missing and might have provided other important contributions to the research. That said the data provided insights helping to understand mentors' experiences of supporting students in remote settings, helping to change practice locally in the way that mentors are supported.

How mentors see their role in promoting students' professional development on clinical placement.

Enhancing and promoting the profession emerges as one of the key drivers for mentors in undertaking the role. The role of mentor, bound up in the mentors' sense of self and intrinsic to them as registered nurses, seems to provide the basis for commitment to the role. Having a sense of pride in the profession is suggested as a key motivation for mentors to 'pass on' to the next generation of nurses their skills, knowledge and passion. This pride in their profession is a stimulus for mentors to be the 'best that they can be' and pass on this attitude to their students, 'Fostering student learning' provides a means for mentors to influence the future of the profession. As they 'Foster student learning' it is

suggested that mentors see themselves as 'nurturing' their students, adopting the persona of 'mother' or guardian to develop them. In the context of a remote setting this element of the mentor role is heightened and the mentors' pastoral role extended, cognisant that students are often far removed from usual support networks. 'Fostering student learning' involves mentors providing students with an authentic role to help overcome initial awkwardness and unfamiliarity with ways of working. Introducing students to the team and including them in social activities is an important element of 'Fostering student learning'; however, there is an important distinction to be made between this social and emotional support and the ways in which a welcome is extended to include students in a professional sense. 'Fostering student learning' includes the vital element of providing students with the opportunity to make a meaningful contribution, so that learning can fully develop. This is legitimate peripheral participation as described by Lave and Wenger (1991) an important dimension of 'Fostering student learning'.

How mentors support students across the 4 domains identified by the NMC (2004).

I now consider what the tentative theory of 'Fostering student learning' can provide in contributing to how mentors support students in their professional and ethical practice, care delivery, care management and personal development. In the first instance, it seems that mentors provide social support by welcoming students into the clinical placement, fostering a sense of belonging. The mentors are providing a 'back up' or 'safety net' for their students as they gain confidence in their new clinical environment, and move towards achieving proficiency across the four domains to achieve the NMC(2004) standard of proficiency. Mentors seem to be acting as 'role models' and 'coaches' to their students across all the 4 domains,

these seem particularly essential as tools to pass on 'craft knowledge' (Spouse, 2001a).

The importance of close working relationships is therefore vital so that mentees can observe and learn from their mentors as they go about their work. 'Use of self' in this way can have a significant impact upon students' practice as it is possible that much learning might occur at a subliminal level as mentors work alongside their mentees as they go about their day to day work together. Students are able to witness the application of ethical and professional principles in day to day practice, such as demonstrating respect for patients and ensuring that patients' dignity is not compromised. Mentors also use strategies such as reflection and debriefing as tools to help students appreciate the learning that had taken place. Such tools can be used to discuss and 'tease out' the learning derived from observing and participating in care delivery and management, thus acknowledging the 'subliminal' learning that may have taken place. Using student assessment documentation on a 'contemporaneous' basis as an 'aid memoire' to aid reflection upon the learning seems advantageous in 'Fostering student learning'.

In order to 'Foster student learning', mentors must provide students with an opportunity to make an authentic contribution to the work. As mentees' skills and knowledge are unlikely to be fully developed this contribution need not be central to the work but should be meaningful if their learning is to be progressed. 'Fostering student learning' involved use of the practice environment in that mentors provided practice and observation opportunities to promote care delivery and care management skills. The clinical placement holds a potential range of learning opportunities for students to which mentors provide access, helping

students to achieve required learning outcomes for the placement. In 'Fostering student learning' it is the culture of the placement and general approach to learning that seems of crucial significance in enabling access to appropriate learning opportunities for mentees.

Factors that influence mentors' ability to promote student learning.

A variety of factors can impact upon the way in which 'Fostering student learning' occurs, this can be viewed in terms of structural, managerial and personal factors. Adequate time to support students in practice is seen as an essential requirement to ensure optimal student learning can occur. Heavy workloads, inadequate staffing levels and competing demands, both of patient care and clinical management can all impact negatively upon time to support students in practice. Added to which, as the pastoral role of mentors is amplified, this adds to the pressures that mentors face supporting students in remote placements. Mentors' skills in juggling competing responsibilities and in supporting students in their own time mitigate these negative influences in 'Fostering student learning'. To 'Foster student learning' mentors also draw upon support from colleagues and from the wider practice education team, Practice Education Facilitators (PEFs) and Practice Education Lecturers (PELs). However, it seems that it is the personal dimension that mentors bring to the role that largely determines the success of how learning is 'fostered' in clinical settings. The ability to 'Foster student learning' seemed influenced by the confidence of the mentor in carrying out the role. This seems not to be entirely dependent upon the formal preparation that has been undertaken. Mentors own self-belief and feelings of self-worth seems built up through

experience and reinforced by positive mentoring experiences. Motivation and confidence seems to hinge upon Bandura's (1986) notions of self-efficacy.

Summary

The tentative theory 'Fostering student learning' has emerged from the research findings and is suggested as a way of viewing mentors' experiences of supporting pre-registration nursing students in remote settings. Mentors seem to heighten the pastoral element of their mentor role to help students integrate into both new clinical and social environments. Mentors and the wider team appear to take on the role of a 'surrogate family', nurturing students, taking account of their vulnerability in such situations. The mentors seem to act as 'coaches' rather than 'teachers' but do not always appreciate the significance and value of their own 'craft knowledge' that they pass on to students. They are instrumental in providing students with an 'authentic role' so that learning can take place. Underpinning all of this is a passion to 'pass on' to their students a pride in 'being the best that you can be' in caring for another person.

Recommendations arising from this research

In this section I consider recommendations for future practice arising from my research findings and the tentative theory that has emerged from analysis of the data. I would hope that they might add to debate nationally when my research findings are able to reach a wider audience by means of publication.

Strategies recommended for enhancing mentor-mentee contact time pre-placement

Mentors describe the anxiety that students can experience when on placement in remote settings, removed from usual support networks. They describe how the pastoral elements of their role have to be increased to fill this breach and ensure that students are supported adequately both professionally and personally. Given that the pastoral element of the mentors' role may be very significant, it would be appropriate for their personal relationship to be established as early as possible. For remote placements this could be achieved by utilising technologies such as 'video link'. The Practice Education Facilitator (PEF) or Practice Education Lecturer (PEL) should take responsibility for establishing individual student contact, thus forming stronger links for information exchange to help alleviate student anxiety at the earliest opportunity. Students could be encouraged in this way to access placement profiles 'on line' and be well prepared prior to placement.

- Students should be encouraged and supported in preparing fully for clinical placement experience
- This should include pre-placement contact with mentor, facilitated by PEF or PEL, to help establish mentor-mentee relationship as soon as possible

Strategies recommended for giving greater recognition to the important role of mentor and for maximising mentor-mentee contact time in clinical placement

Given that this research has confirmed the crucial role that mentors play in supporting students in practice by 'Fostering student learning', organisational and

management strategies should be adopted to give greater recognition to the role of the mentor. An important aspect of this is to ensure that mentors have sufficient time and resources to undertake their important work. It seems that mentors 'coach' their students as they go about their work together and if this support is to be of a high standard staffing levels and skill mix need to be adequate to ensure that mentors have time to educate learners whilst they deliver care together. The findings of the study reveal that mentors struggle at times to support their students adequately. Whilst they do seem to manage this, it is sometimes achieved at a personal cost to the mentors as they 'juggle' demands. This is evidenced in the data both in terms of the 'pressure and stress' that they experience, the 'guilt' they reported feeling and in the time that they commit to student support in their own 'off duty' periods. In reality, a call for increased staffing levels is unlikely to be met in these times of funding pressures. However, there are a number of actions that might be taken at clinical placement level to develop a culture in which the mentor role is given more status and mentor-mentee time is given a higher priority. This would help to ensure that the NMC (2008a) requirement that 40% of student time must be supervised by a mentor is being met. A recommendation is that all mentoring arrangements must be clearly documented in student assessment documentation. Formal recording of mentor-mentee contact time should be made explicit on student timesheets, placement duty rotas and within assessment documentation. This might help to focus more attention on this important requirement. It would seem prudent to maximise the amount of time that mentors can spend with their mentees. Some mentors reported that they had to deputise for more senior staff, for example Irene (Chapter 4, p.106) and this was problematic as it diverted attention away from their mentees . This should be highlighted as a problem when duty rotas are drawn up and avoided if at all

possible. Where such situations cannot be avoided, clear alternative mentoring arrangements for students should be made.

A student 'charter' (Appendix 19) could be developed by mentors in collaboration with their students as a way of formalising the commitments and responsibilities of both parties whilst on placement. The stimulus for devising this draft has arisen from the findings of the research, which indicated that mentor-mentee time should be maximised so that mentors can transmit their knowledge to students by working side by side with them. Such a draft charter is suggested as a means of raising awareness amongst all members of the clinical team of the importance of the role of mentor in practice education. This might be effective if displayed prominently in clinical areas.

- Staffing levels and skill mix to be addressed so that mentors have time to educate learners whilst delivering care
- Duty rotas, student timesheets and assessment documentation clearly demonstrate that NMC (2008a) requirements for mentor supervision time have been met
- Clear alternative mentoring arrangements made explicit on duty rotas to cover times when mentors are deputising for more senior staff
- Consideration given to development of student 'charter' making explicit commitments of both student and mentor in clinical placement, to highlight the importance of the mentor role in supporting student education

Strategies recommended for establishing continuity in mentor-mentee relationships and placements

To 'Foster student learning' in remote settings mentors seem to expend considerable time and energies in orientating their students, not only to their new clinical situation but also to their new wider social environment. In 'Fostering student learning' mentors establish personal relationships and spend time developing a supportive culture in which to 'nurture' their mentees. However, with current arrangements, students are rather transient members of the team, moving on and being replaced by another student at the end of their only placement experience in this setting. Mentors must then begin again establishing a new relationship, orientating their new student to both the workplace and to the wider social environment. It is therefore recommended that where placements can offer adequate breadth and depth of learning opportunities, consideration be given to developing 'Hub' placements in island settings, where students could return for at least one placement annually, being reunited with their mentors. This could offer many advantages from both a mentor and student perspective. A returning student might enhance the satisfaction and fulfilment that mentors experience, as they are able to witness student development over a longer period, something they say is important to them. Continuity in terms of mentoring would be maximised. Students, returning to a more familiar environment, might have an enhanced feeling of 'belonging' and be able to access an 'authentic role' more quickly as less time is required to adapt to an environment that is familiar. For students who cannot access the 'Hub' model, placement length should be such that it allows for an adequate 'settling in' period.

- Extend and develop the use of remote/island placements as a base for students, to which they can return annually to enhance continuity in terms of mentor support
- Offer placement experiences that are of sufficient duration to allow students to 'settle in' to new living and working environments

Strategies to support mentors effectively 'Fostering student learning'

This research has revealed that mentors are presented with unique challenges in supporting students on remote clinical placements due to the geographical location and size of such placements. The data revealed that mentors support their students in dealing with a number of personal issues, which if not handled well have the potential to impact negatively upon student learning in placement. This seems to add to the pressures that mentors face as they provide this social support to their students both in the workplace and wider community. It is recommended that opportunities are provided for mentors to exchange experiences with their peers, so that this knowledge base can be shared and developed and so that mentors can derive support from their colleagues. Such support might be provided at mentor 'de-brief' sessions, facilitated by Practice Education Facilitator (PEFs) or Practice Education Lecturers (PELs), where facilitated discussion could take place in a supportive environment. Sharing learning in this way might be helpful as mentors could reflect on their experiences of student support and learn from each other following each cohort of student learners.

Participant mentors acknowledged their role and accountability with regard to student assessment; however, this was an area that challenged them, especially when dealing with a weak student, where mentors seemed to find it difficult to provide robust feedback. Mentors should be provided with more support in how to provide feedback to students, with PEF and/or PEL available to support mentors at mid-placement and final assessment meetings with weak students. Mentor workshops/update sessions should provide the forum for discussion regarding the principles of providing effective feedback and assessment, complying with the NMC (2008a) requirement for annual updating. In such a setting mentors could share experiences with colleagues in a non-threatening environment and receive feedback from their peers on how to handle difficult student behaviours. Mentors should have the support of PEFs and PELs as well as support of fellow mentors and senior charge nurses and line managers in devising action plans to help students develop to achieve competence. This might provide mentors with more confidence in this difficult area of their role.

Participant mentors seemed to devalue the importance of the 'craft knowledge' they shared with students in favour of more formal teaching or 'book' knowledge. Helping mentors to value their own 'craft knowledge' is important and could be achieved at mentor update sessions. For example, the data revealed that mentors used such strategies as role modelling, coaching, scaffolding, fading and reflection to help convey their skills and knowledge to their students. Including a discussion of the theoretical basis for such learning approaches in a mentor update sessions might help mentors to appreciate the value of what they do on a day to day basis. To reinforce the importance of this learning, mentors should be encouraged to use student assessment documentation more contemporaneously as a means of

aiding continuous discussion, reflection and learning rather than only as the place where summative assessment is recorded at the end of the placement.

- Opportunities should be provided for mentors to explore the pastoral elements of their role and share learning with peers. This might be achieved at mentor 'debrief' sessions following each 'cohort' of students
- Encouraging the use of student assessment documentation as a means of continuous discussion, reflection and learning rather than only as the place were summative assessment is recorded at the end of placement would help to reinforce the importance of learning in practice
- Stressing to mentors the need to carefully observe students' clinical practice as a means of identifying learning need as a 'diagnostic' tool as well as for summative assessment
- Mentors should be provided with more support so that they can feel confident in their assessment decisions and provide robust and fair feedback to students
- Support of PEF and PEL should be utilised in providing opportunities for mentors to practice their skills in workshop settings and in supporting mentors to give direct feedback to students and with action planning
- Mentor update sessions should be used to help mentors value their own professional knowledge rather than feel the need to transmit formal 'book' knowledge, mentors should be helped to communicate this by coaching skills
- Mentor debrief sessions and update sessions are recommended as a forum for providing mentors with feedback from students, so that they can act to

do things differently if required and be shown appreciation for what has gone well, enhancing self-worth and bolstering confidence

In this chapter I have explained the tentative theory 'Fostering student learning' and how the three themes of 'Having a student', 'Passing it on' and 'A surrogate family' emerged from the data, discussing my findings and the theory in relation to what they can provide in answering my research questions. In the next and final chapter, I go on to present my own evaluation of what I have done, considering what I have learned and what I would do differently having undertaken this project.

6. Evaluation

In this final chapter I present an evaluation of the study in terms of the research design, the key findings, its strengths and limitations. I consider what I would have done differently with the benefit of hindsight and what I will do differently in my professional practice as a result of my research. I then go on to a more personal reflection in which I consider the learning that I have derived from undertaking this programme of study. Trying to gain an understanding of the world through the eyes of others has provided valuable personal insights for me. I conclude the chapter and end this thesis with an articulation of what I consider to have been this most significant learning.

Evaluating my research

From the vantage point of this very final chapter of my thesis, I look back across the project and inevitably find that there are things that I would have done differently, as I now go on to discuss in this evaluation of my thesis. Reviewing my introductory chapter I hope that I have provided the reader with a clear sense of the context in which I currently work and the drivers that motivated me to undertake the research. In this opening chapter I aimed to set out both my personal and research ambitions and as I now reflect upon them I can say that most were achieved to some degree.

Looking back to the literature that I chose to review and discuss in Chapter 2, I feel that this choice was appropriate. Reviewing the existing literature helped me to gain an understanding of the history of the role and how it has moved

incrementally to its current manifestation. My review of the literature provided me with a detailed knowledge of the issues and concerns that were topical regarding mentoring within the profession and from my analysis I was able to develop and focus my own research questions. Reading widely and thinking deeply about the mentor role and educational theory enhanced my own confidence as my knowledge base increased. I adopted an analytical approach when reviewing research studies and this honed my skills in this respect but I am aware that I am still developing my writing skills in presenting this review.

The Research design

My choice of methodology was helpful to me and relevant to my research aspirations. I set out to gain an understanding of the experiences of a small group of mentors in a remote island location when I embarked upon this project. My lack of skills in undertaking research may have hampered the process, as I discuss in more detail below, but I found it reassuring to be guided by grounded theory methodology in the collection and analysis of the data. By this means I have been able to put forward answers to my research questions, suggesting a tentative theory 'Fostering student learning'. Drawn from the data as they are, my research findings offer new insights into the way that mentors view their practice in a remote context, demonstrating the appropriateness of a grounded theory approach.

Data collection

With regard to my data collection methods, I consider vindicated in my choice of interviews as the main data gathering tool in that participants spoke in an uninhibited way and appeared to freely share their experiences with me. Much

rich data were generated as mentors provided candid accounts as they engaged with me, which I consider to be a key strength of the study. Whilst pleased with the data generated, I do confess to a poor interview technique at least in the early stages of data collection. Reviewing the transcripts now I feel embarrassed at my first attempts at interviewing. My style sometimes a 'remorseless interrogation' and during some interviews I spoke almost as much as the interviewees. I found it difficult to concentrate on the answers to my questions and frame appropriate and timely responses. I am sure that my inability to respond sufficiently quickly to probe participants' responses may have lost opportunities to gain important insights. On a more positive note, as the project progressed my interviewing technique improved. This was evident in later interviews in which a more relaxed, 'quiet' approach from me bore many fruits in terms of mentors' willingness to speak openly about their experiences. This was a key learning point for me.

My use of diaries as a data gathering tool had mixed success. In retrospect, I should have thought more clearly about what I wanted to know, balanced against what could be realistically expected of busy clinicians who were doing me a favour. I had hoped to gain some accurate estimates of the time that mentors spent with mentees undertaking mentoring activities. This proved not to be possible as mentors did not provide this detail consistently. With hindsight, it was naïve of me to expect mentors to complete this level of detail, requiring them to 'log' their mentoring activities almost contemporaneously as they went about their work. However, the diaries did provide me with an overview of the types of mentoring activity undertaken. The 'open' comments sections were more successful. The entries were often brief but they provided qualitative data of mentors' experiences, substantiating findings gained from 'first round' interviews

and helping to focus 'second round' interviews. Reviewing the diaries, I had suspicions that they had been completed retrospectively, possibly in one 'sitting' just before I was to collect them. Some mentors commented on the usefulness of diaries in aiding their reflection on their mentoring role. With this in mind, I think that a diary design that sought only to elicit 'free' responses from mentors, at intervals decided by them, might have been more worthwhile. Mentors would have had more of a 'free reign' to provide information they considered important, captured at a time convenient to them, rather than complying with my pre-determined diary format. This would have been more congruent with my qualitative approach. Also, gathering data over a shorter time period, of say 6 weeks rather than 12 weeks, might have been less onerous for mentors. This would have still provided an adequate time frame in which to capture the breadth of mentor experience, avoiding a 'snap-shot' that may have been atypical in a shorter period. These adaptations to the diary format and reduction in time spent on data collection might have been beneficial in terms of mentor engagement and consequent volume and richness of data generated.

Strengths and Limitations

The small scale of the research, with only 10 mentor participants, might be considered a limitation of the study. However, this number was adequate in generating rich data contributing to understanding of mentors' experiences of supporting students. I believe that the 'thick descriptions' of my categories allows readers to vicariously experience mentors' professional 'lives'. My findings, for example, that mentors heighten their pastoral role when students are removed from usual support networks, can help to change practice locally. For instance, I

can focus more support in helping mentors to deal with personal issues that students raise.

Recruiting mentors to the study relied upon an advertisement. I was relieved that any mentor, current on the locally held mentor register, responded to my request for help with my research. I considered that these research participants, whilst not selected by means of 'purposive sampling' strategies, were likely to provide valid and useful information to help answer my research questions, in keeping with my grounded theory approach. I acknowledge that having volunteered to take part they are likely to be amongst the most interested in and committed to their role. In the main they were experienced mentors and this is representative of the overall profile of the mentors on the locally held mentor register, there being very few newly qualified practitioners. In evaluating my study, which included no newly qualified mentors, I have considered what might have been different if they had agreed to take part. Such mentors would not have experienced 'first hand' the history of mentor role development. This may have led to different perspectives in terms of how they viewed the nature of mentorship captured within the category 'it's part and parcel of nursing', in which mentors were rather dismissive of official titles ascribed to them over the years. Also, new mentors may not have built up an extensive repertoire of skills in terms of how they 'pass on' their skills and knowledge to mentees and therefore the data may not have been so wide-ranging in this respect. Overall, I do not consider that my tentative theory of 'Fostering student learning' would be fundamentally changed. The study might also be criticised for its lack of a student perspective and I acknowledge that student insights would have been valuable in adding to understanding of the mentor-student dynamic. However, given the very small scale of this research, and time

limits imposed by the EdD programme, I stand by my decision to include only mentors so that I could focus on their experiences, an area that has received much less research interest in the literature.

The small nature of the study, conducted within a very small Health Board area posed challenges in other respects with regard to my research design, in particular regarding the 'power dynamics' between me and the participants. I have discussed ethical considerations in Chapter 3 in some detail and the impact of my 'insider' status on the research. The regional ethics committee were reassured that mentors were not pressurised to take part in the study and I have provided detail of how I took account of the consequences of being an 'insider' researcher (Appendix 12). The strategies I adopted to ameliorate the negative consequences of my insider status seem to have been effective in eliciting frank and honest accounts from the mentors. Conducting research with so few participants in such a small Health Board area, has also led me to reconsider the assurances that I gave to mentors regarding anonymity at the start of the study. I assigned pseudonyms to mentors and have taken all reasonable precautions to remove references that might help identify individuals. However, in this age of the internet, it would not be difficult to identify the Health Board area in which this research took place. With numbers so small it might then be possible for readers to recognise a particular 'turn of phrase' used in quotations that might identify an individual mentor. In retrospect, I should have made this clearer to participant before issuing 'cast iron' assurances of anonymity.

I consider a strength of the research to be the way in which I transcribed audio recordings of interviews myself, very meticulously checking and rechecking the

transcripts. In doing so, I believe that I captured a very accurate version of what happened during interviews. This meant that I had sound source data upon which to begin my analysis. Furthermore, adopting this painstaking approach meant that I was very familiar with the data as Strauss and Corbin advise (1998), essential in adopting a grounded theory approach. It is important that the researcher is 'steeped' in the data when commencing the process of analysis, and I feel that I did achieve this.

The degree to which my findings are transferable were not fully explored during this study. With hindsight, I could have made formal contact with practice education colleagues in other Health Board settings seeking their comments regarding the transferability of the findings. However, in my Practice Educator role informal communication with colleagues in other remote settings has revealed similar experiences regarding how mentorship takes place. Others will make judgements about the relevance of findings when they reach a wider audience by means of publication.

Coding and analysis of the data

I have already referred to my short comings in terms of my lack of skills as a novice researcher. I think that these were most evident when it came to analysis of my research data. Coding is one of the most central processes in grounded theory (Bryman, 2008) but it is also the most difficult aspect for a novice researcher, in terms of understanding and operation (Strauss, 1987). Bryman (2008) points out that one of the main difficulties with qualitative research is that it rapidly generates large volumes of cumbersome data because of its reliance on prose, such as

interview transcripts. Whilst I was pleased with the richness of the data gathered, I was daunted by the volume and frequently asked myself, 'How do I deal with all of this?' A systematic approach to analysis of the data was essential if I was to do justice to it, increase my understanding and allow me to present what I had discovered to others. I stand by my decision to reject the use of a computer software programme to assist with analysis of the data, my rationale for which is given in my research design chapter. However, this is tinged with some regret, in that I missed an opportunity to extend my research skills. This decision made, I found that manual analysis of my data was very time consuming, a period of uncertainty and slow progress. I now ponder whether the use of a software programme would have made the process easier to manage.

In order to aid me in the process of data analysis I read the literature widely for examples of how Strauss and Corbin's (1998) guidance had been applied by others. However, authors seemed to be using their own modified versions of the coding process, or failed to provide detailed descriptions of how they went about it. Bryman (2008) states that unlike the analysis of quantitative data, there are few well established, widely accepted rules for the analysis of qualitative data. This lack was disconcerting. Furthermore, trying to grasp the detail of how other researchers had carried out their coding was confusing, the terms 'codes', 'categories', 'elements', 'concepts' and 'themes' seemed to be used synonymously by many researchers making it difficult for me to understand the level to which their research had progressed. I certainly struggled with this element of my project, lacking in confidence that I was adhering to 'correct' procedures made me very hesitant in my approach. However, I now understand that whilst differences exist in the way that it is achieved the coding process provides a

means of moving from microanalysis of data to more abstract ways of conceptualising it. My research design chapter may have given the impression that coding of the data was undertaken mechanistically, whereas in reality coding in qualitative research is not an exact science but one that is 'in a constant state of potential revision and fluidity' (Bryman, 2008, p. 542). I was supported in this by my supervisor who provided regular feedback, so that with perseverance the process of coding and interpreting the data eventually became clearer. I have provided in my research design and findings chapters detail of how I undertook the process of data analysis so that readers can follow how I have interpreted the data by following my data analysis process. In doing so I would hope that another researcher would agree with the tentative theory that I have put forward and with the conclusions and recommendations that I have reached.

The key findings of my research

A number of key findings emerged from my research adding new insights to mentors' experiences of supporting students in the context of a remote and rural setting as I present and discuss in Chapters 4 and 5. The finding that in remote settings mentors seem to enhance their pastoral role to deal with challenges that might not arise when students are able to remain within usual networks of support is significant. Mentoring strategies to help students integrate and demystify local culture in such situations are essential. This was a point noted by Mills (2007) in an Australian study. However, I think that my findings are of merit in advancing knowledge of mentor experience as very little research exists in remote UK island settings. That conducted by Littlejohn (1992), with a sample size of 4, relating to pupil nurses has little to contribute to contemporary practice.

Many aspects of mentor experience uncovered in this research were not specific to a remote location and have been reported in the literature previously. For example, heavy workloads, inadequate staffing levels and competing demands, both of patient care and clinical management, all reduced time available to support students. However, I would argue that my findings are valuable in that they corroborate aspects of this previous research (Aston et al., 2000, Aston and Molassiotis, 2003, Gray and Smith, 2000, Dolan, 2003, Myall et al., 2008, Nettleton and Bray, 2008, Carlisle et al., 2009). My findings also add an additional dimension in that mentors in remote placements have extra pressures on their time as they support students' integration into their new environments in a practical, personal as well as professional sense.

Presentation of findings

The tentative theory 'Fostering student learning', comprising the themes 'Having a student', 'Passing it on' and 'A surrogate family', is a conceptual representation of the experiences of the participant mentors. Presenting my findings in this way necessarily involved the distillation of large amounts of qualitative data and I have described the grounded theory approach I adopted in doing so. My challenge has been to present the data in such a way that readers are convinced of its trustworthiness and of the credibility of my claims in interpreting it in such a way. As a new researcher, I was very excited with the data that was generated, wanting to incorporate swathes of interview transcripts into this report to illustrate mentor perspectives. My imposed word limit for this final report precluded this and in any case I soon realised that to convince the reader of the veracity of my

interpretations I needed to discuss and justify my findings. I have done so by providing 'thick descriptions' of my categories and provided detail of how I interpreted the data, how my categories developed and themes emerged. In evaluating my research design I have described how I struggled with the process of data analysis, and as a clinician and novice researcher I think that this is understandable as the process was completely new to me. I believe that I have been able to meet the requirements of grounded theory and naturalistic research designs by being systematic in the development of categories.

What Have I Learned?

My learning with regard to carrying out this research project has been multifaceted. In this section I consider learning that has taken place at a more personal level. I have decided to employ a modified version of Gibbs' (1998) reflective model to help me to do so and avoid what Carolan (2003, p. 13) describes as 'a self-indulgent form of navel-gazing'.

Describe

As a first step Gibbs asks us to describe 'the event' in succinct, 'matter of fact' terms. This is no easy task given that so much psychological and emotional effort is bound up in the process of undertaking a research project such as this. I commenced the programme in May 2007 and suspended my studies in March 2008 for 6 months due to problems with my health and other personal issues. I then progressed according to the prescribed study schedule submitting this final thesis in October 2011.

Feelings

My feelings during this journey of learning have ranged from elation to despair! Having undertaken a first degree and Master's degree with The Open University I looked forward to study at doctoral level. I hoped to gain new insights that I could apply to better support mentors and students in the workplace as well as gain a valued academic qualification. In retrospect, I feel that I was very naïve when I began my project, not fully appreciating what was required at this level of study. I got off to a faltering start, partly but not entirely, due to the personal issues previously mentioned. I did not deal well with the uncertainty that I now understand is often integral to establishing and carrying out a project as a lone researcher. Despite support from my supervisor I felt that I prevaricated for many months in making decisions about my research design and became despondent when I received initial rejection from the regional research ethics committee. I have subsequently learned that few research applications are given clearance without further consideration; Dixon-Woods et al. (2007) cite overall figures in the region of only 15%. However, at the time I felt this was a considerable blow. The application process was lengthy and I felt the pressure of time upon me as deadlines for The Open University loomed. This, accompanied by uncertainty about research methodology and nagging doubts about my own academic abilities and time management skills resulted in a loss of confidence. This could strike when I least expected it and caused me to lose weeks of work. It was all very undermining and led me to seriously consider withdrawing from the programme. However, encouragement from my supervisor and the incremental nature of the EdD programme bolstered my flagging confidence. As progress reports were submitted and 'Year One' report completed, with positive feedback, I felt my confidence levels begin to slowly rise.

Most importantly, I valued the time that busy mentors spent with me, providing such rich data that I wanted to do my best to 'tell their story'. I began to enjoy the academic challenge of crafting a piece of work I hoped would do justice to their faith in me. Mentors spoke very candidly about their desire to 'be the best that you can be' and how they tried to instil this into their mentees. Their words had resonance for me. Canfield (2007, p. 245) tells us to 'Practice Persistence' and that most people give up when they are just about to achieve success. At the time of writing I am unsure whether this project will be deemed an academic success. I hope it will be judged as such but I have come to realise that success can be defined in many ways. I feel that the learning gained in both personal and professional terms has been hugely worthwhile, as I now go on to consider.

Evaluation

In the cycle of reflection suggested by Gibbs, we are asked to consider what has been good and bad about the experience. Overall my experience has been positive. One of my main objectives in undertaking this research was to help me to understand more about the research process itself. I feel that I have achieved this aim. Conducting a literature review, grappling with theoretical frameworks, methodologies and research instruments all enhanced my knowledge and understanding. I have also enjoyed the 'writing up' of the project and believe that my writing skills have developed. The structure of the Open University's EdD, requiring as it did the submission of reports at regular intervals, ensured that formal writing was an integral part of the project. This helped in the process of creating a fluent account of my research. It took me some time to realise that my writing was not 'all or nothing'. Burton (2000, p.432) recounts the experiences of a

researcher who likewise thought that what was written had to be either 'priceless literary pearls or unmitigated garbage'. I came to understand that drafting and redrafting was part of a process that would hopefully lead me to authoring a thesis at an acceptable level. I tried to follow the advice of Murray (2002, p. 7) who suggests that 'learning comes through writing, quality comes through revision and regular writing develops fluency'. This in mind, I was able to 'release the brakes', write more freely and move forward.

Learning began at the very start of the programme. For example, I was able to share my experiences of writing a research proposal and of negotiating the complex NHS ethics approval process with colleagues starting out on research projects. By means of interview I gained access to data of such vividness that my understanding of mentorship was hugely enhanced. I was pleased that mentors were able to speak so openly to me. I began to more fully appreciate the challenges inherent within the mentor role locally. This made me consider how I could better support mentors. As a direct result I have introduced a number of initiatives that I believe have improved mentor experiences of supporting students. For example, I have introduced 'debrief' sessions for mentors in which they are able to reflect upon and learn from their recent experiences of supporting students. These are classroom based sessions facilitated by me, held at the end of each student cohort allocation, that provide a forum for mentors to share learning and gain support from peers. The content of these sessions is led by mentors but typically can include discussion of student feedback and devising action plans to address issues as appropriate. These sessions have been well evaluated by mentors, who seem to value the support of colleagues. Mentor update sessions have also been revised with the aim of helping mentors value their 'craft

knowledge' and how they convey this to students, rejecting the notion that formal, theoretical knowledge is superior.

As a result of my research I feel that I have a much greater connection with the mentors and a deeper understanding of the challenges they face. I have begun to view my role in a different way, and to see myself more clearly as a vigorous advocate for them and the important work they do. I think this will be essential in the future when reduced staffing levels may increase pressures upon mentors to an even greater extent.

I have valued the personal insights I have gained. I have always considered myself to be a determined person and having set goals I like to achieve them. I confess to having been slightly dismissive of those who quit a course of study with what I might previously have considered excuses. Having come close to leaving the programme myself, I find that I can empathise with and offer support to those who find themselves in a similar situation with much greater understanding, and humility! Also, pre and post registration students with whom I have contact have been interested to hear that I am studying too. Camaraderie has developed between us as we have exchanged views on effective study techniques. It has been a positive experience to have this connection with them. I think that I have been an advocate for 'Lifelong learning' and have demonstrated that age should never be considered a barrier to study!

The most negative aspect of undertaking the project has been the difficulty of trying to undertake a major piece of academic work whilst juggling full time employment and family commitments. A number of personal crises arose whilst I

was enrolled on this programme. As an Open University student of many years standing I acknowledge that such setbacks are inevitable and have to be dealt with whilst still achieving study targets. However, part time study at this level is demanding and for much of the project I have felt under considerable pressure. Covey (2004, p. 287) reminds us of the importance of 'balanced self-renewal' but achieving a reasonable 'work- life' balance has been difficult. Yet, as the project draws to a conclusion, I feel that I have learned much about my own resilience and can advise and support students, who also have many competing demands upon their time, with much greater credibility.

Analysis – What Sense Can I Make Of It?

Walford (1991) argues that the 'messiness' of the research process is not always reflected in the literature. As a novice researcher I found this uncertainty to be very disconcerting. This was particularly true in the early stages when I found that significant aspects of my study were undecided. In her book, 'Achieving a PhD- ten students' experience', Salmon (1992) presents the candid reflections of doctoral students. This was useful in helping me to understand that my experiences were not unusual. Students spoke of their fears, lack of confidence and, above all, their desire for someone to tell them what to do! Their words reflected my experiences exactly and this was reassuring. I now realise that there is as much learning to be gained from undertaking the process of research as there is in the product of that research.

The 'authoring' of this research project has proved to be unexpectedly enjoyable. Dunleavy (2003, p. 5) offers an explanation as to why this might be so. He states

that, 'Doing good research and becoming an effective author are not separate processes, but closely related aspects of intellectual development that need to work in parallel'. Producing regular progress reports has required drafting, re-drafting, reflection upon and re-evaluation of my work on an on-going basis. This has necessitated frequent engagement with the theory of adult learning and mentorship and consideration of how this relates to my own work. This has helped me to understand my findings and to appreciate what my research has really been about. I think that I have made a contribution to the understanding of mentor experience, particularly when that experience is set in a remote location. The frank accounts that I have been able to elicit from mentors have helped me to understand their roles and my own with greater clarity.

Conclusion

I have emerged from this experience with many lessons learned. As a novice researcher, the structure of the EdD was very helpful in driving progress. However, there was always an imminent deadline to be met and this constant pressure impacted upon some of my decision making. Drawing upon this experience I think that I will be able to deal in a more confident and measured way with such time pressures in any further research I undertake. For the future, my aspiration is to publish findings arising from this research, for example, on the implications of the heightened pastoral role that mentors seem to demonstrate in supporting students in remotes settings.

I was very pleased to be awarded a Florence Nightingale research scholarship to partially fund this project on the basis of some of the work undertaken. I intend to

fulfil my commitment to produce a report summarising my work and present my findings to the awards committee.

Action Plan

When this project is completed I would like to undertake further research in the area of practice education. I do not have detailed plans at this stage but would see further projects as an opportunity to develop as a researcher, for example, gaining proficiency in the use of such software packages such as NVivo for the purposes of data analysis. This will expand my repertoire of skills in relation to the handling of qualitative data. I have been rather 'old fashioned' in my avoidance of new technologies and I am keen to rectify this. I will explore the use of electronic means of storing and retrieving my references by accessing 'Refworks'. My word processing skills are adequate but I will undertake the 'Advanced European Computer Driving Licence' to increase my confidence in using all the formatting features of my computer.

From a professional point of view there are a number of issues to address. Whilst some of the recommendations arising from my research have been implemented locally, there is still much to do to ensure that mentor support continuously improves. I intend to work with colleagues in practice to consider ways in which the role of the mentor can be strengthened as I have described in Chapter 5.

I regard my experience of undertaking this project as an 'apprenticeship' that has provided me with a very sound basis in how to proceed in any future research undertaking. I have learned that I still have much to learn but I am keen to undertake further research in the area of Practice Education. I see this as a very

positive way to approach the future as a more confident but always very thoughtful and reflective researcher.

References

Abraham, A. (2011) *Care and Compassion, Report of The Health Service Ombudsman on 10 investigations into NHS Care of Older people* [online] http://www.ombudsman.org.uk/__data/assets/pdf_file/0016/7216/Care-and-Compassion-PHSO-0114web.pdf (Accessed 31 August 2011).

Andrews, M. and Chilton, F. (2000), 'Student and Mentor perceptions of mentoring effectiveness', *Nurse Education Today,* 20, pp.555-562.

Andrews, M. and Roberts, D. (2003) 'Supporting student nurses learning in and through clinical practice: the role of the clinical guide' *Nurse Education Today,* vol. 23, pp.474-481.

Andrews, M. and Wallis, M. (1999) 'Mentorship in Nursing: a literature review', *Journal of Advanced Nursing*, vol. 29, no. 1, pp. 201-207.

Andrews, M., Brewer, M., Buchan, T.,Denne, A.,Hammond, J.,Hardy,G.,Jacobs, L.,McKenzie, L.,West,S. (2010) 'Implementation and sustainability of the nursing and midwifery standards for mentoring in the U.K', *Nurse Education in Practice,* 10, pp. 251-255.

Anforth, P. (1992) 'Mentors, not assessors', *Nurse Education Today,* vol. 12, no. 4, pp.299-302.

Armitage, P. and Burnard, P. (1991) 'Mentors or preceptors? Narrowing the theory practice gap'. *Nurse Education Today,* vol. 11, no. 3, pp.225-9.

Aston, L. Mallik, M., Day, C., Fraser, D. (2000) 'An exploration into the role of the teacher/lecturer in practice: findings from a case study in adult nursing', *Nurse Education Today,* vol.20, pp. 178-188.

Aston, L. and Molassiotis, A. (2003) 'Supervising and supporting student nurses in clinical placements: the peer support initiative', *Nurse Education Today,* vol.23, pp. 202-210.

Atkins, S. and Williams, A. (1995) 'Registered nurses experiences of mentoring undergraduate nursing students', *Journal of Advanced Nursing*, vol.25, no.5, pp.1006-1015.

Atkinson, R.L., Atkinson, R.C., Smith, E.E., Bem, D.J., Nolen-Hoeksema, S. (2000, 13th ed.) *Hilgard's Introduction to Psychology,* USA, Harcourt.

Baillie, L. (1993) 'Factors affecting student nurses' learning in community placements: a phenomenological study', *Journal of Advanced Nursing,* vol. 18, pp. 1043-1053.

Baillie, L., Gallagher, A., Wainright, P. (2008) Defending Dignity, Challenges and Opportunities for Nursing, [online] http://www.rcn.org.uk/__data/assets/pdf_file/0011/166655/003257.pdf (Accessed 31 August 2011).

Baglin, M.R. and Rugg, S. (2010) 'Student nurses' experiences of community-based practice placement learning', *Nurse Education in Practice,* vol.10, pp. 144-152.

Bandura, A. (1977) *Social Learning Theory,* Englewood Cliffs, N.J., Prentice-Hall, Inc.

Bandura, A. (1986) *Social Foundations of Thought and Action,* Prentice-Hall, Englewood Cliffs, New Jersey.

Banyard, P. and Hayes, N. (1994) *Psychology, Theory and Application,* London, Chapman and Hall.

BBC. (2011) 'NHS Scotland nurse and midwife numbers fall by 700' [online] http://www.bbc.co.uk/news/uk-scotland-13944750 (Accessed 22 July 2011).

Bell, J. (2010) *Doing Your Research Project,* England, Open University Press, McGraw-Hill Education.

Bond, M. and Holland, S. (1998) *Skills of Clinical Supervision for Nurses.* Buckingham, Open University Press.

Bowling, A. (2009, 3rd edn) *Research methods in Health. Investigating Health and Health Services*, Berkshire, McGraw-Hill Education, Open University Press.

Bray, L. and Nettleton, P. (2007) 'Assessor or mentor? Role confusion in professional education', *Nurse Education Today,* vol.27, pp. 848-855.

Bruner, J.S. (1966) *Towards a Theory of Instruction,* Cambridge, Harvard University Press.

Bryman, A. (2008) *Social Research Methods,* Oxford University Press.

Burgess, H., Sieminski, S., Arthur, L. (2006) *Achieving Your Doctorate in Education,* London, The Open University.

Burnard, P. (1990) 'The student experience: adult learning and mentorship revisited', *Nurse Education Today,* vol. 10, pp. 349-354.

Burton, D. (2000) 'Writing a Thesis' in Burton, D. (ed) Research *Training for Social Scientists,* London, Sage.

Buzan, T. and Buzan, B. (2003) The Mind Map Book. BBC Active, England.

Cahill, H.A. (1996) 'A qualitative analysis of student nurses' experiences of mentorship', *Journal of Advanced Nursing* vol. 24, pp. 791-799.

Cahill, H.A. (1997) 'What should nurse teachers be doing? A preliminary study', *Journal of Advanced Nursing* vol. 26, no.1, pp. 146-153.

Calman,L.,Watson,R., Norman,I.,Redfern,S.,Murrels,T. (2002) 'Assessing practice of student nurses: methods, preparation of assessors and student views', *Journal of Advanced Nursing,* vol.38,no.5,pp.516-523.

Campbell, A.V. (1984) *Moderated Love,* London, SPCK.

Canfield, J. (2007) *How to Get from Where You Are to Where You Want to Be,* London, HarperElement.

Carlisle, C., Calman, L., Ibbotson, T. (2009) 'Practice-based learning: The role of practice education facilitators in supporting mentors', *Nurse Education Today,* vol.29, no.7, pp.715-72.

Carolan, M. (2003) 'Reflexivity: a personal journey during data collection', *Nurse Researcher,* vol.10, no.3, pp.7-14.

Carr, J., Heggarty, H., Carr, M., Fulwood, D., Goodwin, C., Walker, W., Whittingham, K. (2010) 'Reflect for success: recommendations for mentors managing failing students', *British Journal of Community Nursing,* vol.15, no.12, pp.594-596.

Chow, F.L.W. and Suen, L.K.P. (2001) 'Clinical Staff as mentors in pre-registration undergraduate nursing education: students' perceptions of the mentors' roles and responsibilities'. *Nurse Education Today,* vol. 21, no. 5, pp. 350-358.

Clifford, C. (1994) 'Assessment of clinical practice and the role of the nurse teacher', *Nurse Education Today,* vol. 14, pp. 272-279.

Clynes, M.P. and Raftery, S.E.C. (2008) 'Feedback: An essential element of student learning in clinical practice', *Nurse Education in Practice,* no.8, pp. 405-41.

Concise Oxford Dictionary. (1982 7th edn.) Sykes, J.B. (ed.) Oxford, Oxford University Press.

Cope, P., Cuthbertson, P., Stoddart, B. (2000) 'Situated learning in the practice placement', *Journal of Advanced Nursing*, vol. 31, no. 4, pp. 850-856.

Corlett, J. (2000) 'The perceptions of nurse teachers, student nurses and preceptors of the theory-practice gap in nurse education', *Nurse Education Today,* vol. 20, pp.499-505.

Covey, S.R. (2004) *The 7 Habits of Highly Effective People,* London, Simon and Shuster.

Crooks, D.L. (2001) 'The Importance of Symbolic Interaction in Grounded Theory Research on Women's Health', *Health Care for Women International,* vol. 22, pp. 11-27.

Cutcliffe,J.R. and McKenna,H.P. (2004) 'Expert qualitative researchers and the use of audit trails', *'Journal of Advanced Nursing',* vol.45,no.2,pp.126-135.

Darling, L.A. (1984) 'What do nurses want in a mentor?' *Journal of Nursing Administration.* vol. 14, no.10, pp. 42-44.

Darling, L.A. (1985) 'What to do about toxic mentors', *Journal of Nursing Administration,* vol. 15, no.5 pp. 43-44.

Davies, E. (1993) 'Clinical role modelling: uncovering hidden knowledge', *Journal of Advanced Nursing,* vol.18, 627-636.

Denzin, N. (1989 3rd ed.) The Research Act: A Theoretical Introduction to Sociological Methods. New Jersey, Prentice Hall.

Department of Health. (2004) *The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process [online]* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090843 (accessed 15th October 2011).

Dixon-Woods, M., Angell, E., Ashcroft, R.E., Bryman, A. (2007) 'Written work: The social functions of the Research Ethics Committee letters', *Social Science and Medicine,* vol.65, pp.792-802.

Dockrell, W.B. (1988) Ethical considerations in research, in Keeves, J.P. (ed) Educational Research, Methodology and Measurement: an international handbook, pp. 180-185, Oxford, Elsevier Science Ltd.

Dolan, G. (2003) 'Assessing student nurse clinical competency: will we ever get it right?', *Journal of Clinical Nursing,* vol. 12, no. 1, pp. 132-141.

Donaldson, J.H. and Carter, D. (2005) 'The value of role modelling: Perceptions of undergraduate and diploma nursing (adult) students', *Nurse Education in Practice,* vol.5, pp. 353-359.

Donovan, J. (1990) 'The concept and role of mentor', *Nurse Education Today,* vol. 10, pp.294-298.

Duffy, K. (2003) Failing students: A Qualitative investigation of factors that influence the assessment of students' competence to practice. Glasgow Caledonian University. [online] http://www.nmc-uk.org/Documents/Archived%20Publications/1Research%20papers/KathleenDuffy_Failing_Students2003.pdf (accessed 31 August 2011).

Duffy, K.,Docherty,C.,Carnuff, L.,White,M.,Winters,G., Greig,J.(2000) 'The nurse lecturer's role in mentoring the mentors', *Nursing Standard,* vol.15, no.6, pp.35-38.

Dunleavy, P. (2003) *Authoring a PhD-How to Plan, Draft, Write and Finish a Doctoral Thesis or Dissertation,* Hampshire, Palgrave Macmillan.

Earnshaw, G. J. (1995) 'Mentorship: the students' views'. *Nurse Education Today,* vol. 15, pp. 274-279.

Ehrich, L., Tennent, L., Hansford, B. (2002) 'A review of mentoring in education: some lessons for nursing'. *Contemporary Nurse,* vol. 12, pp. 253-264.

Eisner, E. (1992) 'Objectivity in Educational Research: Current Issues' in Hammersley, M. (ed) *Educational Research,* London, Paul Chapman Publishing.

van Eps, M.A., Cooke, M., Creedy, D.K., Walker, R. (2006) 'Student evaluations of a year-long mentorship program: A quality improvement initiative', *Nurse Education Today,* vol.26, pp.519-524.

Felstead, A., Fuller, A., Unwin, L., Ashton, D., Butler, P., Lee, T. (2005) 'Surveying the scene: learning metaphors, survey design and the workplace context'. *Journal of Education and Work,* vol.18, no. 4, pp. 359-383.

Fitzgerald, M., Gibson, F., Gunn, K. (2010) 'Contemporary issues relating to assessment of pre-registration nursing students in practice', *Nurse Education in Practice,* vol.10. pp. 158-163.

Francis, R. (2010) Independent Inquiry into care provided by Mid Staffordshire NNS Foundation Trust January 2005- March 2009 [online] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113447.pdf (Accessed 31 August 2011).

Gibbs, G. (1988) *Learning by Doing: A guide to teaching and learning methods. Further Education Unit.* Oxford, Oxford Brookes University.

Glaser, B. and Strauss, A. (1967) *The Discovery of Grounded Theory.* New Brunswick, Aldine.

Gray, M.A. and Smith, L.N. (1999) 'The professional socialization of diploma of higher education in nursing students (Project 2000): a longitudinal qualitative study'. *Journal of Advanced Nursing.* vol.29, no. 3, pp.639-647.

Gray, M.A. and Smith, L.N. (2000) 'The qualities of an effective mentor from the student nurse's perspective: findings from a longitudinal qualitative study'. *Journal of Advanced Nursing,* vol.32, no. 6, pp.1542-1549.

Guba,E. and Lincoln, Y. (1989) *Fourth Generation Evaluation.* California, Sage publications.

Hall, A. (2006) 'Mentorship in the community', *Journal of Community Nursing,* vol.20, no. 7, pp.10-12.

Hand, H. (2003) 'The mentor's tale: a reflexive account of semi-structured interviews', *Nurse Researcher,* vol.10, no.3, pp.15-17.

Hart, G. and Rotem, A. (1995) 'The clinical learning environment: nurses perceptions of professional development in clinical settings', *Nurse Education Today,* no.15, pp.3-10.

Hellawell, D. (2006) 'Inside-out: analysis of the insider-outsider concept as a heuristic device to develop reflexivity in students doing qualitative research', *Teaching in Higher Education,* vol.11, no.4, pp.483-494.

Higginson, R. (2006) 'Fears, worries and experiences of first-year pre-registration nursing students: a qualitative study', *Nurse Researcher,* vol. 13, no. 3, pp.32-49.

Hochschild, A. (1983) *'The Managed Heart',* Berkeley, University of California Press.

Holloway, I. and Todres, L. (2006) 'Grounded Theory', in Gerrish, K. and Lacey, A., (eds) *The Research Process in Nursing*, Great Britain, Blackwell.

Holstein, J.A. and Gubrium, J.F. (2004) 'The active interview' in Silverman, D. (ed) *Qualitative Research, Theory, Method and Practice*. London, Sage.

Hutchings, A., Williamson, G.R., Humphreys, A. (2005) 'Supporting learners in clinical practice: capacity issues' *Journal of Clinical Nursing,* vol.14, pp.945-955.

Jackson, P. (2000) *'Writing Up Qualitative Data'* in Burton, D. (ed) *Research Training for Social Scientists,* London, Sage.

Jarvis, P. and Gibson, S. (1997) *The Teacher, Practitioner and Mentor in Nursing and Midwifery, Health Visiting and the Social Services*, Cheltenham, Stanley Thornes (Publishing) Ltd.

Jinks, A.M. (2007) 'Methodological considerations of undertaking research with clinical mentors in the UK: A critical review of the literature, *Nurse Education Today,* vol.7, pp.667-676.

Jinks, A.M. and Williams, R.H. (1994) 'Evaluation of a community staff preparation strategy for the teaching, assessing and mentorship of Project 2000 diploma students', *Nurse Education Today,* vol. 14, pp. 44-51.

Kenyon, L. and Peckover, S. (2008) 'A Juggling Act': An analysis of the impact of providing clinical placements for pre – registration students on the organisation of community nursing and health visiting work', *Nurse Education Today,* vol. 28, pp. 202-209.

Kinnell, D. and Hughes, P. (2010) *Mentoring Nursing and Healthcare Students,* London, Sage.

Knowles, M. S. (1998) 'Introduction: The Art and Science of Helping Adults Learn' in Downie, C.M., Basford, P. (eds) *Teaching and Assessing in Clinical Practice. A Reader,* London, Greenwich University Press.

Koch, T. (1994) 'Establishing rigour in qualitative research: the decision trail', *Journal of Advanced Nursing,* vol.19, pp.976-986.

Lave, J. and Wenger, E. (1991) *Situated Learning: Legitimate Peripheral Participation.* Cambridge University Press.

Lave J. and Wenger, E. (2002) 'Legitimate participation in communities of practice', in Harrison, R., Reeve, F. Hanson, A. Clarke, J. (eds) *Supporting Lifelong Learning Volume 1: perspectives on learning.* London. Routledge/The Open University.

Levett-Jones, T. and Lathlean, J. (2008) 'Belongingness: A prerequisite for nursing students' clinical learning', *Nurse Education in Practice,* no.8, pp.103-111.

Le Gallais, T. (2003) *From native to stranger...and back again? Questions for reflective practitioners.* [online] www.leeds.ac.uk/educol/documents/00003363.doc (accessed 28 February 2012).

Littlejohn, L. (1992) 'Effects of mentorship on learners', *British Journal of Nursing,* vol.1, no.9, pp. 452-454.

Lloyd Jones, M., Walters, S., Akenhurst, R. (2001) 'The implications of contact with the mentor for preregistration nursing and midwifery students' *Journal of Advanced Nursing,* vol.35, no.2, pp.151-160.

Mangione, T. W. (1995), *Mail Surveys: Improving the Quality.* Thousand Oaks, California, Sage.

Marton, F. and Saljo, R. (1976) On qualitative differences in learning 1. Outcome and process. *British Journal of Educational Psychology,* vol. 46, pp. 4-11.

McKinley, M.G. (2004) 'Mentoring Matters: Creating, Connecting, Empowering', *Advanced Practice in Acute Critical Care,* vol. 15, no.2, pp. 205-214.

Middleton, R. and Duffy, K. (2009) 'Mentoring a student immediately prior to registration: a qualitative study', *British Journal of Community Nursing,* vol.14, no.2 pp.481-486.

Miles, B. and Huberman, A.M. (1994) *Qualitative Data Analysis,* Thousand Oaks, California, Sage.

Miller, J. and Glassner, B. (2004) 'The 'Inside' and the 'Outside' Finding Realities in Interviews' in Silverman, D. (ed) *Qualitative Research, Theory, Method and Practice.* London, Sage.

Milligan, F. (1998) 'In defence of Andragogy. Part 2. An Educational Process Consistent with Modern Nursing's Aims', in Downie, C.M., Basford, P., (eds) *Teaching and Assessing in Clinical Practice. A Reader,* London, Greenwich University Press.

Mills, J., Francis, K., Bonner, A. (2007) 'Live my work: rural nurses and their multiple perspectives of self, *Journal of Advanced Nursing,* vol.59, no.6, pp. 583-590.

Morle, K. M. F. (1990) 'Mentorship- is it a case of the emperors new clothes or a rose by any other name?', *Nurse Education Today,* vol. 10, pp. 66-69.

Morse, J.M. and Field, P. A. (1996) Nursing Research: The Application of Qualitative Approaches, London. Chapman and Hall.

Moseley, L.G., Mead, D.M., Moran, L. (2004) 'An empirically- derived clinical placement evaluation tool: a 3-country study', *Nurse Education Today,* 24, pp. 350-356.

Murray, R. (2002) *How to Write a Thesis,* U.K., Open University Press.

Myall, M., Levett-Jones, T., Lathlean, J. (2008) 'Mentorship in contemporary practice: the experiences of nursing students and practice mentors', *Journal of Clinical Nursing,* vol. 17, pp. 1834-1842.

Neary, M. (1997) 'Defining the role of assessors, mentors and supervisors: part 2', *Nursing Standard,* vol. 11, no. 43 pp. 34-38.

Neary, M. (2000a) 'Supporting students' learning and professional development through the process of continuous assessment and mentorship', *Nurse Education Today,* vol.20, pp.463-474.

Neary, M. (2000b) Teaching, Assessing and Evaluation for Clinical Competence. A practical guide for practitioners and teachers. Cheltenham: Nelson Thornes Ltd.

Nettleton, P. and Bray, L. (2008) 'Current mentorship schemes might be doing our students a disservice', *'Nurse Education in Practice',* vol. 8, pp. 205-212.

NHS Education for Scotland. (2007) *National Approach to Mentor Preparation for Nurses and Midwives Core Curriculum Framework,* Edinburgh, NES.

NHS Education for Scotland. (2008, 2nd edn), *Quality Standards for Practice Placements, Edinburgh,* NES.

NHS Education for Scotland. (2011) *Developing a National Approach to Practice Assessment Documentation for the Pre-registration Nursing Programmes in Scotland,* Edinburgh, NES.

Nicklin, P.J. and Kenworthy, N. eds, (2000) *Teaching and Assessing in Nursing Practice,* London, Bailliere Tindall.

Nursing and Midwifery Council. (2004) *Standards of proficiency for pre-registration nursing education,* London, NMC.

Nursing and Midwifery Council. (2006) *Standards to support learning and assessment in practice.* London, NMC.

Nursing and Midwifery Council. (2008a, 2nd edn.) *Standards to support learning and assessment in practice.* London, NMC.

Nursing and Midwifery Council. (2008b) *The Code, Standards of conduct, performance and ethics for nurses and midwives,* London, NMC.

Nursing and Midwifery Council. (2009) *Guidance for the care of older people.* London, NMC.

Nursing and Midwifery Council. (2010) *Standards for pre-registration nursing education* [online] http://standards.nmcuk.org/PublishedDocuments/Standards%20for%20pre-registration%20nursing%20education%2016082010.pdf (accessed 23 June 2011).

Nursing Times. (2010) www.nursingtimes.net /whats-new-in nursing/news-topics (Accessed 30th April 2011).

Oakley, A. (1981) 'Interviewing women', in Roberts, H. (ed) *Doing Feminist Research,* London and New York, Routledge.

Oppenheim, A.N. (1992) Questionnaire Design, Interviewing and Attitude Measurement. London. Continuum.

Parahoo, K. (2006) Nursing Research, Principles, Process and Issues. London, Palgrave Macmillan.

Pearcey, P.A. and Elliot, B.E. (2004) 'Student impressions of clinical nursing', *Nurse Education Today,* vol. 24, pp. 382-387.

Pellat, G.C. (2006) 'The role of mentors in supporting pre-registration nursing students', *British Journal of Nursing,* vol. 15, no.6, pp. 336-340.

Perry, B. (2009) 'Role modeling excellence in clinical nursing practice', *Nurse Education in Practice,* vol.9, 36-44.

Peshkin, A. (1998) 'In search of subjectivity-One's own', *Educational Researcher,* vol. 17, no.7, pp. 17-21.

Phillips, D.C. (1989), 'Subjectivity and Objectivity: An Objective Inquiry' in Hammersley, M. (ed) *Educational Research,* London, Paul Chapman Publishing.

Phillips, R.M., Davies, W.B., Neary, M. (1996a) 'The practitioner-teacher: a study in the introduction of mentors in the preregistration nurse education programme in Wales: part 1', *Journal of Advanced Nursing,* vol.23, no.5, pp.1037-1044.

Phillips, R.M., Davies, W.B., Neary, M. (1996b) 'The practitioner-teacher: a study in the introduction of mentors in the preregistration nurse education programme in Wales: part 2', *Journal of Advanced Nursing,* vol.23, no.6, pp.1080-1088.

Phillips, T., Schostak, J., and Tyler, J. (2000) 'Practice and Assessment in Nursing and Midwifery: Doing it for real' in *Assessing Practice in Nursing and Midwifery.* The Open University.

Piemme, J.A., Kramer, W., Tack, B.B., Evans, J. (1986) 'Developing the nurse preceptor', *Journal of Continuing Education in Nursing,* vol.17, no.6, 186-189.

Polgar, S. and Thomas, S.A. (2008) *Introduction to Research in the Health Sciences,* London, Churchill Livingstone Elsevier.

Polit,D.F. and Beck,C.T. (2006) *Essentials of Nursing Research,* USA, Lippincott, Williams and Wilkins.

Powney, J. and Watts, M. (1987) *Interviewing in Educational Research,* London, Routledge and Kegan Paul Ltd.

Pulsford, D., Boit, K., Owen, S. (2002), 'Are mentors ready to make a difference? A survey of mentor's attitudes towards nurse education', *Nurse Education Today,* vol. 22, pp. 439-446.

Purdy, M. (1998) 'Humanist Ideology and Nurse Education. 1. Humanist Educational Theory', in Downie, C.M., Basford, P., (eds) *Teaching and Assessing in Clinical Practice. A Reader*, London, Greenwich University Press.

Quality Assurance Agency for Higher Education. (2007, 2nd edn), *Code of practice for the assurance of academic quality and standards in higher education. Section 9: Work- based and placement learning.* Mansfield, QAA.

RCN. (2008) Nursing our future, London, RCN. [online] http://www.rcn.org.uk/__data/assets/pdf_file/0008/197756/003306.pdf (accessed 23 June 2011).

Riley, J. (1996) *Getting the most from your data,* U.K., The Cromwell Press.

Robson, C. (2002, 2nd edn.) *Real World Research.* Blackwell, Oxford.

Rogers, C.R. (1967) *On Becoming a Person.* U.K. Constable.

Rogers, C. R. (2002) 'The interpersonal relationship in the facilitation of learning', in Harrison, R., Reeve, F., Hanson, A., Clarke, J. (eds) *Supporting Lifelong Learning Volume 1: perspectives on learning.* London. Routledge.

Rowntree, D. (1987) *Assessing students: How shall we know them?,* London, Kogan Page.

Salmon, P. (1992) *Achieving a PhD – ten students' experience,* Stoke on Trent,Trentham Books.

Sandelowski, M. (1998) 'The Call to Experts in Qualitative Research', *Research in Nursing and Health,* vol. 21, pp. 467-471.

Schreiber, R.S. and Stern, P.N. (2001) *Using Grounded Theory in Nursing,* New York, Springer.

Scott, D. (1997) 'The researcher's personal responses as a source of insight in the research process', *Nursing Inquiry,* vol.4. no. 2, pp. 130-134.

Silverman, D. (2004, 2nd edn) Qualitative Research, Theory, Method and Practice, London, Sage.

Smith, P. and Gray, B. (2001) 'Reassessing the concept of emotional labour in student nurse education: role of link lecturers and mentors in time of change', *Nurse Education Today,* vol.21, no.3, pp.230-237.

Spouse, J. (1998a) 'Scaffolding student learning in clinical practice', *Nurse Education Today,* vol.18, no. 4, pp. 259-266.

Spouse, J. (1998b) 'Learning to nurse through legitimate peripheral participation', *Nurse Education Today,* vol. 18, no. 5, pp. 345-351.

Spouse, J. (2000) 'An impossible dream? Images of nursing held by pre-registration students and their effect on sustaining motivation to become nurses', *Journal of Advanced Nursing,* vol.32, no.3, pp.730-739.

Spouse, J. (2001a) 'Workplace learning: pre-registration nursing students' perspectives', *Nurse Education in Practice,* vol. 1, no.3, pp.149-156.

Spouse,J. (2001b) 'Bridging theory and practice in the supervisory relationship: a sociocultural perspective', *Journal of Advanced Nursing,* vol. 33, no.4, pp. 512-522.

Spouse, J. (2001c) 'Work-based learning in health care environments', *Nurse Education in Practice,* no.1, pp.12-18.

Strauss, A. and Corbin, J. (1998, 2nd edn) Basics of Qualitative Research: techniques and procedures for developing grounded theory, Thousand Oaks, Sage.

Strauss, A.L. (1987) Qualitative Analysis for Social Scientists. Cambridge University Press, New York.

Stroh, M. (2000) 'Qualitative Interviewing', in Burton, D. (ed) *Research Training for Social Scientists,* London, Sage.

Tarling, M. and Crofts, L. (2002, 2nd edn) *The Essential Researcher's Handbook,* London, Baillière Tindall, London.

Tesch, R. (1990) Qualitative Research, analysis types and software tools. Abingdon. RoutledgeFalmer.

Thomas, G. and James, D. (2006) 'Reinventing grounded theory: some questions about theory, ground and discovery'. *British Educational Research Journal,* vol. 32, no.6, pp.767-795.

Tobin, G.A. and Begley, C.M. (2004) 'Methodological rigour within a qualitative framework', *Journal of Advanced Nursing,* vol. 48, no.4, pp.388-396.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1986) *Project 2000: A New Preparation for Practice,* London, UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1999). *Fitness for Practice: UKCC Commission for Nursing and Midwifery Education.* London, UKCC.

Vygotsky, L.S. (1986) *Thought and Language,* Kozulin, A. (Trans), Cambridge, MA. MIT Press.

Walford, G. (1991) 'Reflexive accounts of doing educational research', in G. Walford, (ed) *Doing Educational Research,* London and New York, Routledge.

Watson, N. (1999) 'Mentoring today –the students' views. An investigative case study of pre-registration nursing students' experiences and perceptions of mentoring in one theory/practice module of the Common Foundation Programme on a Project 2000 course', *The Journal of Advanced Nursing,*vol.29, no.1,pp. 254-262.

Watson, R., Stimpson, A., Topping, A., Porock, D. (2002) 'Clinical competence assessment in nursing: a systematic review of the literature', *Journal of Advanced Nursing,* vol.39, no. 5, pp. 421-431.

Watson, S. (2000) 'The support that mentors receive in the clinical setting', *Nurse Education Today,* no. 20, pp. 585-592.

Watson, S. (2004) 'Mentor preparation: reasons for undertaking the course and expectations of the candidates', *Nurse Education Today,*no.24, pp. 30-40.

Webb, C. and Shakespeare. P. (2008) 'Judgements about mentoring relationships in nurse education', *Nurse Education Today,* vol. 28, pp. 563-571.

Wertsch, J, V. (1985) *Vygotsky and the social formation of mind.* Harvard University Press. USA.

Wilde, V. (1992) 'Controversial hypotheses on the relationship between researcher and informant in qualitative research', *Journal of Advanced Nursing,* vol. 17 pp. 234-242.

Wilkes, Z. (2006) 'The student-mentor relationship: a review of the literature', *Nursing Standard,* vol.20, no.37, pp. 42-47.

Wilson-Barnett, J., Butterworth, T., White, E., Twinn, S., Davies, S., Riley, L. (1995) 'Clinical support and the Project 2000 nursing student: factors influencing this process' *Journal of Advanced Nursing,* vol.21, no. 6, pp.1152-1158.

Wood,D.,Bruner, J.,Ross, G. (1976) 'The role of tutoring in problem solving', *Journal of Child Psychology,* vol. 17, pp. 89-100.

Appendix 1: Mentor Questionnaire.

My comments in this questionnaire are based on my experiences as a mentor ☐

My comments in this questionnaire are based on my experiences as a deputy mentor ☐

(Please tick whichever applies)

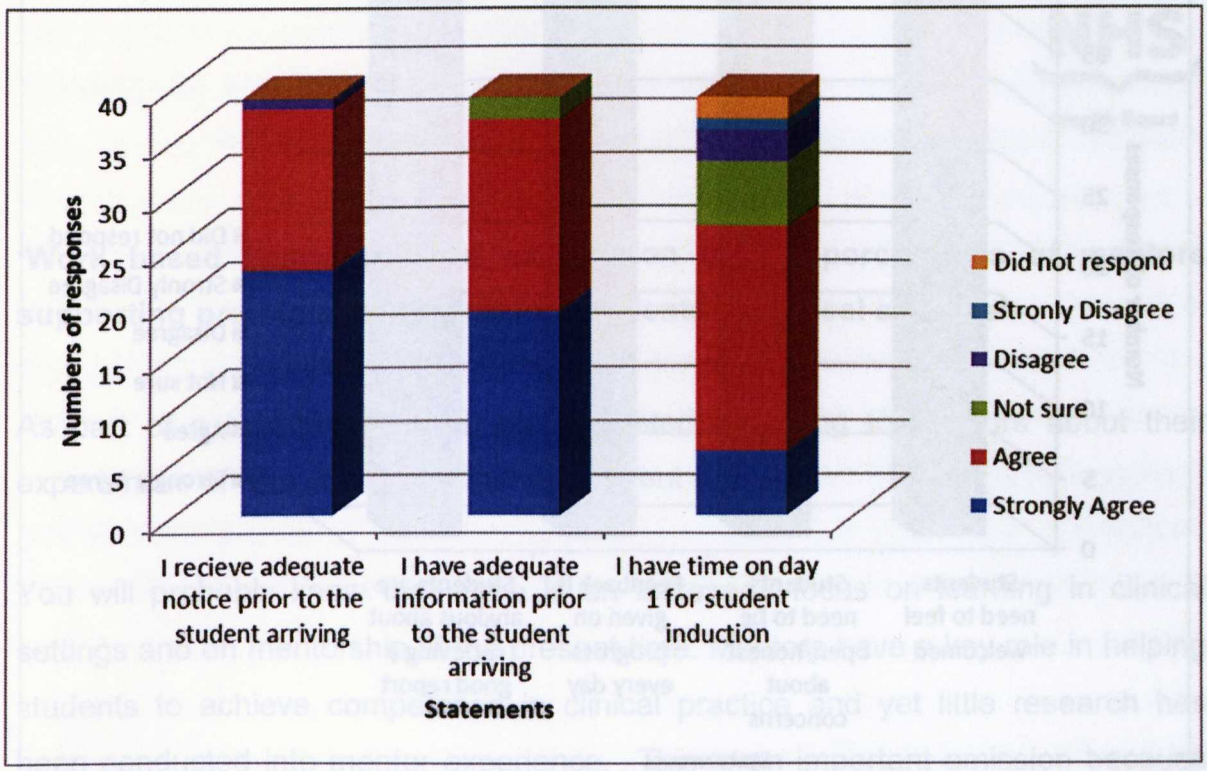
	Strongly agree 5	Agree 4	Not sure 3	Disagree 2	Strongly disagree 1	Comments
Prior to the placement:						
I receive adequate notice prior to the student arriving in my clinical area.						
I have adequate information prior to the student arriving in my clinical placement, *(e.g. programme student is undertaking and stage reached)*						
I have time on day 1 for student induction *(e.g. to show them around placement area)*						
During Practice Placement:						
I discuss my student's learning needs with them during the first week of placement.						
I ensure my student has the opportunity to work with other nursing staff						
I ensure my student has the opportunity to work with other health care professionals						
We have a team approach to supporting students in my work place.						

	Strongly agree 5	Agree 4	Not sure 3	Disagree 2	Strongly disagree 1	Comments
I have freedom/ authority to plan and deliver learning opportunities to meet learning outcomes						
I feel prepared for my role as mentor						
My student and I deliver care together at least 2 shifts per week.						
I know where I can get support if I am worried about my student's progress or conduct. *(Please comment on where you would get support).*						
After Practice Placement:						
There are systems in place by which I can feedback on my experience of mentoring students *(Please comment- to whom would you feedback your experiences)*						
Your views on mentorship:						
I think that students need to feel welcomed to the team.						
My students need to be open and honest about any concerns.						
I give feedback to my student on their progress at least every day that we work together.						
Students are anxious about receiving a good report						
Your comments on your role as a mentor:						

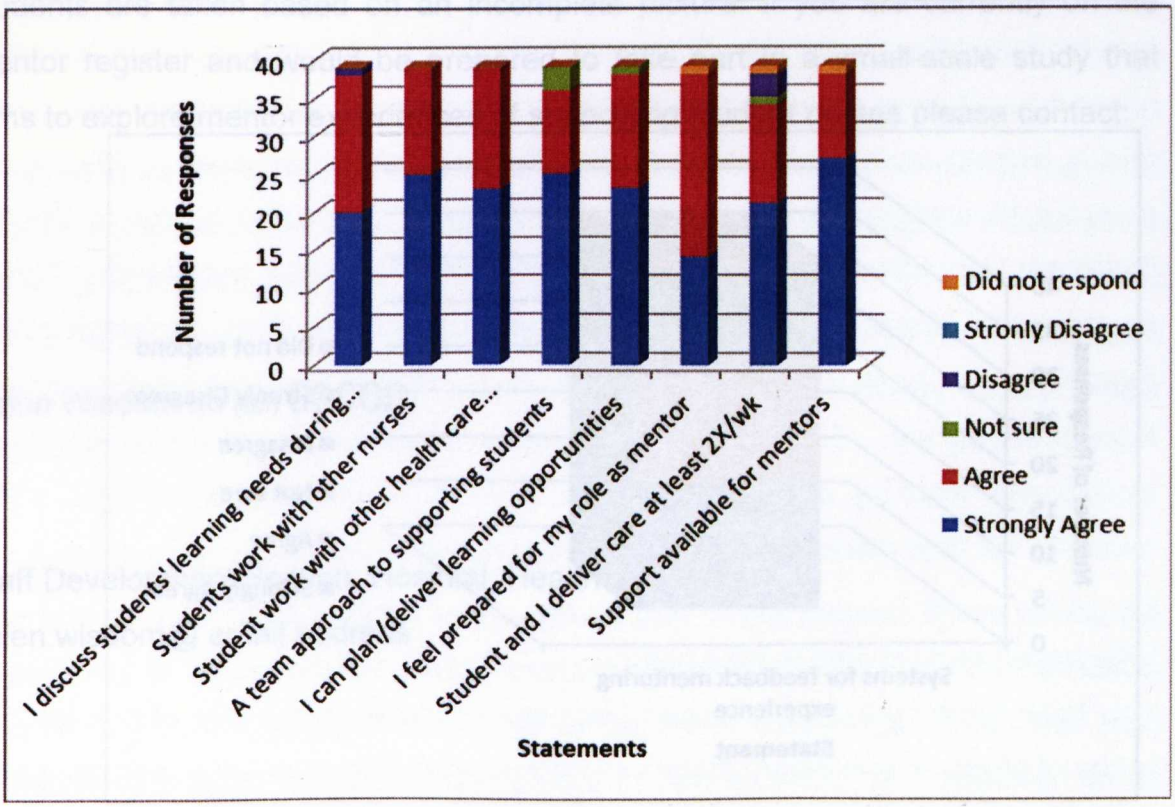
Please make any general comments about your experiences of being a mentor. What do you see as your biggest challenges faced as a mentor, and how you deal with them? Please also comment on any factors that influence the way that you promote student learning. Please continue onto additional sheet if required.

PLEASE RETURN TO HELEN WISDOM, ADDRESS BY DATE
THANK YOU.

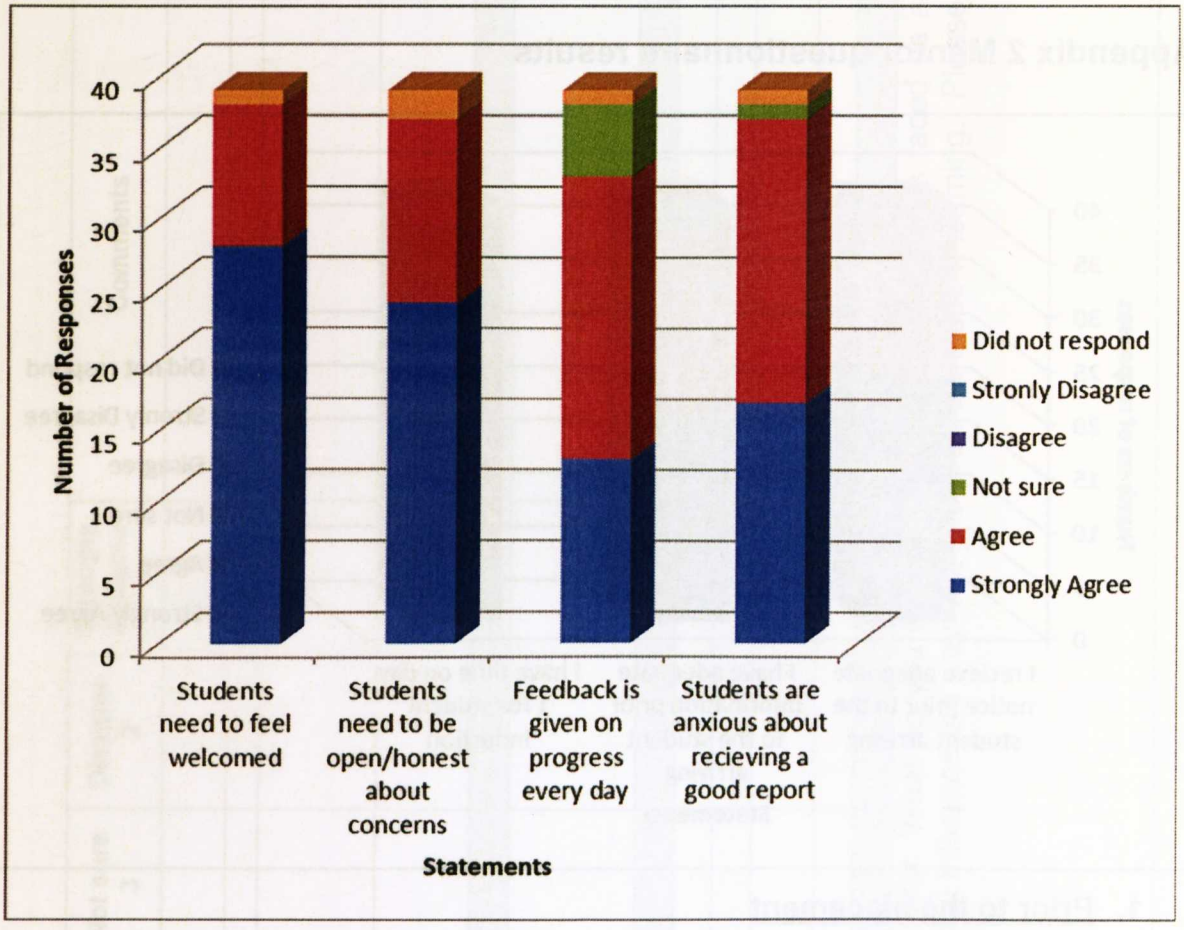
Appendix 2 Mentor questionnaire results



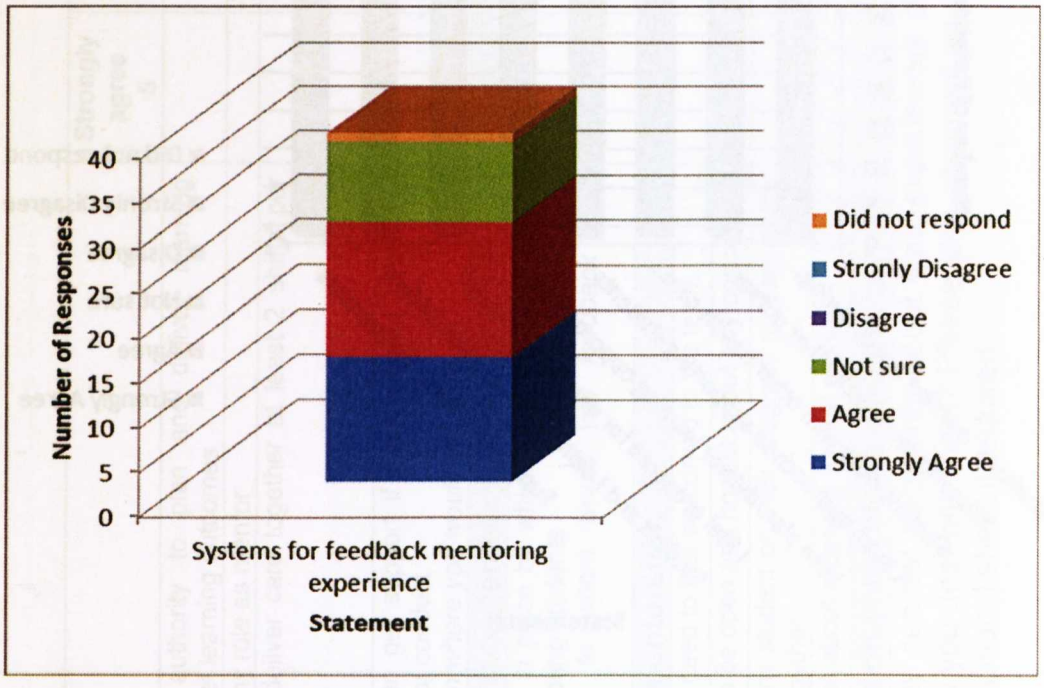
1. Prior to the placement



2. During Practice Placement



3. Mentors' views mentoring



4. Systems for feeding back mentoring experiences

Appendix 3: Advertisement: Initial Recruitment to the Study

NHS
Health Board

'Work based Learning – An exploration of the perceptions of mentors supporting pre-registration nursing students in clinical settings'

As part of a research study I am interested in talking to mentors about their experiences of what it is like to mentor student nurses.

You will probably know that there is an increased focus on learning in clinical settings and on mentorship at the present time. Mentors have a key role in helping students to achieve competence in clinical practice and yet little research has been conducted into mentor experience. This is an important omission because without this information decisions made on how best to support both mentors and students are taken based on an incomplete picture. If you are currently on the mentor register and would be prepared to take part in a small-scale study that aims to explore mentor experiences of supporting student nurses please contact:

Helen Wisdom on (tel) 00000

Staff Development Section, Hospital, Health Board Area,
helen.wisdom@ email address

Appendix 4: Information Sheet for Respondents

Work based learning – An exploration of the perceptions of mentors supporting pre- registration nursing students in clinical settings.

Thank you for responding to my advertisement for mentor volunteers to take part in the above study. I would like to invite you to take part in a research project that I am undertaking as part of an educational qualification. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Please don't hesitate to contact myself if you would like clarification of certain points or further information about the study. Thank you for taking the time to read this information sheet.

What is the project about?

You are probably aware that there is an increased focus on learning in clinical settings and on mentorship at the present time. At least 50% of nurse education programmes take place away from university in the workplace but little is known about how effective learning takes place in clinical settings. Mentors have a key role in helping students to achieve competence in clinical practice. This project sets out to explore mentor views and experience of what it is like to mentor students. Very little research has been conducted into mentor experience. This is an important omission since without information of this kind decisions made regarding how best to support students and mentors are taken based on an incomplete picture. The aim of the project is to explore mentor perceptions of work-based learning and give mentors a voice in this important area. The research will take place over a period of approximately 3 years.

Why have I been invited to take part?

You have been invited to take part because you take on the role of mentor to a range of students at different stages of their pre-registration nursing programmes. I want to gather the views of experienced mentors and mentors who are new to the mentoring role. I aim to recruit and interview between 5-10 mentors as part of this project.

Do I have to take part?

No. It is up to you to decide whether to take part. If you do decide to take part, you will be given this information sheet to keep and will be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will have no adverse consequences to you in any way.

If you agree to take part what will you be asked to do?

You will be invited to meet with me, the researcher, to talk about your experiences of being a mentor. I will have some broad topic areas that I would like to raise with you but the aim is to find out what mentorship is like from your perspective. Therefore, I would be pleased if you would tell me about issues that you feel are important from your point of view. These meetings will take place in a mutually agreed venue, away from your work area, at a time convenient to you. I would anticipate that they would take no longer than one hour. With your agreement the interviews will be recorded on audiotape and then the data will be transcribed. The transcripts will be returned to you to check for the accuracy of your comments. After this initial interview, there may be areas raised that I would like to follow up on and would ask if you would agree to be interviewed again to discuss these areas in more depth. Follow up interviews will follow the same format as the initial interview and would take place several months after the first. Again, if from these follow up interviews there are areas that I would like to discuss with you the format would be the same as before. There is no obligation to agree to future interviews and you will be invited to take part in no more than 3 interviews over a 3-year period.

What are the possible benefits of taking part?

There are no personal benefits to you taking part in this project. There will be the opportunity to reflect upon a very important aspect of your professional practice. You will be contributing to knowledge in an under researched area. This may ultimately contribute to policy development in how students and mentors can be better supported in clinical practice in the future. You will have access to the data gathered from you and you will be able to respond to developing insights from the

analysis of data from all the participants, all comments made will be anonymised and there will be no individual identifiable factors.

Are there any disadvantages or risks to taking part?

No significant risks have been identified in taking part in this study. There will be a time commitment involved in taking part in the study. This should not be onerous, as interviews will last for no longer than one hour. They will take place in an appropriate venue convenient to you. In a 2-year period, the total time commitment will not exceed 2-3 hours.

Will my taking part in this study be kept confidential?

In all accounts of the research, data will be anonymised and confidentiality will be assured. All data will be stored securely and will be destroyed once its use for the purposes of this study has ended. I alone will have access to your own data, names and contact details. I have a responsibility to behave ethically at all times and I will follow the British Educational Research Association's Ethical Guidelines. Permission to conduct the research will be sought from the North of Scotland Research Ethics committee. As I am a registered nurse I must adhere to the NMC Code of Professional conduct, standards for conduct, performance and ethics. As such I must act upon any information revealed during the course of interview that might indicate poor practice in the workplace. I would inform you of my proposed action should this occur.

What will happen to the results of the research study?

The results of the research study will be written up as part of my research thesis and this will be in the public domain. Sections of the findings may be published in professional journals and findings presented at nursing conferences.

Suppose you decide to drop out of the study?

Your decision to take part in this study is entirely voluntary. You may withdraw from the study at any time without giving reasons and will be able to request the destruction of any data that you have given up to that point.

Who has reviewed the study?

Permission to conduct this research has been obtained from The Robert Gordon University, The Open University and the North of Scotland Research Ethics Committee.

What do you need to do now?

Thank you for reading this information sheet and for considering taking part in the research. If you choose not to participate you need do nothing more, I will not contact you again regarding this. If you choose to participate please contact me, Helen Wisdom, at the address given below. You will then hear from me shortly to arrange our first meeting date.

Contact for Further Information

Helen Wisdom
Staff Development Section
Health Board Area
Telephone Number
helen.wisdom@emailaddress

Appendix 5: Consent Form

WORK BASED LEARNING – AN EXPLORATION OF THE PERCEPTIONS OF MENTORS SUPPORTING PRE- REGISTRATION NURSING STUDENTS IN CLINICAL SETTINGS

NAME OF RESEARCHER: HELEN WISDOM

- I confirm that I have read and understand the information sheet dated September 2007 relating to the above study. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction by the researcher.

  Please initial ❑

- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

  Please initial ❑

- I agree to take part in the above study.

  Please initial ❑

- I confirm that I agree to the interview being audio taped. I understand that I will not be identified. I will have the opportunity to view the transcript of my interview and to make amendments

  Please initial ❑

Name of mentor	**Date**	**signature**
Name of person taking consent	**Date**	**signature**

Appendix 6: Information Sheet for those Completing Diaries

NHS
Health Board

Work based learning - An exploration of the perceptions of mentors supporting pre- registration nursing students in clinical settings.

Mentoring Logs

Thank you very much for your contribution to my study to date. By means of interviewing volunteers such as you I have already collected much useful information. In order to help me to understand the experience of being a mentor in greater depth I am now seeking to also collect data by asking volunteers, already taking part in the study, to complete a log when they have contact with students. Please take the time to read this information carefully. Please don't hesitate to contact me if you would like clarification regarding this 'mentoring log' component of the study or for any information at all about my study.

Why have I been invited to complete a log?

As a mentor you are working closely with pre- registration nursing students on a day-to-day basis. The data that I have gathered from interviews has given me a very good overview of mentor experience. However, I would now like to gain more detailed knowledge of what the everyday experience of being a mentor is like. One means of doing this would be for mentors to record the types of learning experiences they provide for students and to comment upon how effective they think that they have been. This would also help me to corroborate my findings by using a variety of methods by which to collect data.

Do I have to complete a mentoring log?

No. It is up to you to decide whether or not you wish to complete a log. If you do decide to take part you will be given this information sheet to keep and will be asked to sign a consent form. If you decide to take part in completing a log, you are free to withdraw at any time, from the entire study or from the 'mentoring log'

component. A decision to withdraw at any time, or a decision not to participate in keeping a log, will have no adverse consequences to you in any way.

If you agree to complete a diary what will you be asked to do?

You would be asked to complete a diary when you are next allocated a student to mentor or are working with a student in the role of 'deputy' mentor. A sample log is attached to this information sheet. You can see that the log is in a week per page view, with a space for each day and a place for comments at the end of each week. Please use the extra comments sheets at the end of the diary if you need more space. Please jot down the mentoring activities that you have been involved in each day if possible and any views on how effective they have been in promoting student learning. Don't worry if you don't manage to record all of your mentoring activities. I understand that the time pressures in clinical practice are such that these logs may not be complete records but any information at all that you can provide would be very helpful. This is not a student record, and students should not be identified by name. It is not a record of student achievement and should not be used for student assessment. **This is simply a log of activities that you undertake with students and your views on how effective these learning opportunities have been.**

What are the possible benefits of taking part?

There are no personal benefits to you in completing a log. However, completing a log will give you the opportunity to reflect upon your mentoring activities. In order to comply with the 'Standards to support learning and assessment in practice' (NMC, 2006) mentors must have mentored at least 2 students within a 3 year period and this log could provide evidence to demonstrate the types of learning opportunities that you provide for students.

Are there any disadvantages or risks in completing diaries?

No significant risks have been identified in taking part in completing a mentor log. There will be a time commitment in completing logs. This should not be onerous as all I am seeking is a note on the types of activities that you undertake with students and your views on their effectiveness. The log would be completed during the period you mentor a student, i.e. one log for a student placement in which you

are the mentor. I would envisage only one log in total to be completed for the purposes of this study.

Will the information I provide in the 'mentoring log' be confidential?
In all accounts of the research, data that you provide will be anonymised and confidentiality will be assured. I will store all data that you provide securely in exactly the same way as the transcribed data from interviews. These diaries will be your property and I will take a copy of them for the purposes of this study. There will be no need to identify you by name in the log and students should **not** be identified in the log.

What will happen to the information that I provide in the log?
The information that you provide in the mentoring log will be written up as part of my research thesis, in the same way as information provided by interviews.

Suppose you decide that you don't want to complete a log of mentoring activity?

Your decision to maintain a mentoring log is entirely voluntary. You may cease to keep the log at any time. You may withdraw from the entire study at any time and you can request the destruction of any data that you have provided to me up to that point.

Who has given permission for 'mentoring logs' to be completed?
The North of Scotland Research Ethics committee has given permission by considering an amendment to the original research proposal.

What do you need to do now?

Thank you for reading this information sheet and for considering keeping a 'mentoring log'. If you decide you do not wish to maintain a log when you next mentor a student you need do nothing more. If you would like to maintain a log, contact me at the address below and you will then hear from me shortly when I can verbally explain how to maintain the log.

Contact for further information:

Helen Wisdom
Staff Development Section
Health Board Area
Telephone Number

helen.wisdom@emailaddress

Appendix 7: Consent Form for 'Mentoring Diary/log'

WORK BASED LEARNING – AN EXPLORATION OF THE PERCEPTIONS OF MENTORS SUPPORTING PRE- REGISTRATION NURSING STUDENTS IN CLINICAL SETTINGS

NAME OF RESEARCHER: HELEN WISDOM

- I confirm that I have read and understand the information sheet dated September 2008 relating to mentoring logs. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction by the researcher.

  Please initial ❑

- I understand that my participation in completing a log is voluntary and that I am free to withdraw at any time, without giving any reason.

  Please initial ❑

- I agree to take part in completing a 'mentoring' log.

  Please initial ❑

- I confirm that I agree to the log being photocopied for use by the researcher. The original log will remain my property. I understand that I will not be identified.

  Please initial ❑

Name of mentor	**Date**	**signature**
Name of person taking consent	**Date**	**signature**

NHS
Health Board

Appendix 8: Correspondence with ethics committee. Confirmation of Ethical Opinion

11 October 2007

Mrs Helen Wisdom
Practice Educator

Dear Mrs Wisdom

Full title of study: **Workbased learning - An exploration of the perceptions of mentors supporting pre- registration nursing students in clinical settings**
REC reference number: **07/S0801/93**

Thank you for your letter of 11 October 2007, responding to the Committee's request for further information on the above research and submitting revised documentation.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

The favourable opinion is given provided that you comply with the conditions set out. You are advised to study the conditions carefully, in particular:

Condition 1: Annual Progress Report

Under the National Research Ethics Service (NRES) regulations NHS Research Ethics Committees are required to monitor research with a favourable opinion. This is to take the form of an annual progress report which should be submitted to the North of Scotland Research Ethics Committee (NOSREC) 12 months after the date on which the favourable opinion was given. Annual reports should be submitted thereafter until the end of the study.

Points to note:

- The first annual progress report should give the commencement date for the study. This is normally assumed to be the date on which any of the procedures in the protocol are initiated. Should the study not commence within 12 months of approval a written explanation must be provided in the 1st annual progress report.

- Progress reports should be in the format prescribed on the NRES website (www.nres.npsa.nhs.uk/applicants/index.htm).

- Progress reports must be signed by the Principal Investigator/Chief Investigator.

- Failure to submit a progress report could lead to a suspension of the favourable ethical opinion for the study.

- Please note the Annual Progress Report is a short 3 page form which is extremely easy to complete.

Condition 2: Notification of Study Completion/Termination

Under the National Research Ethics Service (NRES) regulations researchers are required to notify the Ethics Committee from which they obtained approval of the conclusion or early termination of a project and to submit a Completion/Termination of Study Report. Researchers should follow the instructions on the NRES website (www.nres.npsa.nhs.uk/applicants/index.htm)

Points to note:

- For most studies the end of a project will be the date of the last visit of the last participant or the completion of any follow-up monitoring and data collection described in the protocol.

- Final analysis of the data and report writing is normally considered to occur after formal declaration of the end of the project.

- A Final Report should be sent to the NOSREC within 12 months of the end of the project.

- The summary of the final report may be enclosed with the end of study declaration, or sent to the REC subsequently.

- There is no standard format for final reports. As a minimum we should receive details of the end date and information on whether the project achieved its objectives, the main findings and arrangements for publication or dissemination of research, including any feedback to participants.

- Please note the Completion/Termination of Study Report need only be a summary document and should, therefore, be easy to prepare.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Application	5.4	27 September 2007
Investigator CV		

Protocol		
Peer Review		15 August 2007
Interview Schedules/Topic Guides	1	
Advertisement	1	
Participant Information Sheet	1	
Participant Consent Form	1	27 August 2007
Response to Request for Further Information		
NHS Shetland Lone Worker Policy		
NHS Shetland - Flow chart for lone worker policy		
Ethical Contract	1	
Supervisor's CV: Dr J F Spouse		
Unfavourable Opinion Letter		17 July 2007

R&D approval

All researchers and research collaborators who will be participating in the research at NHS sites should apply for R&D approval from the relevant care organisation, if they have not yet done so. R&D approval is required, whether or not the study is exempt from SSA. You should advise researchers and local collaborators accordingly.

Guidance on applying for R&D approval is available from http://www.rdforum.nhs.uk/rdform.htm.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

Feedback on the application process

Now that you have completed the application process you are invited to give your view of the service you received from the National Research Ethics Service. If you wish to make your views known please use the feedback form available on the NRES website at:

https://www.nresform.org.uk/AppForm/Modules/Feedback/EthicalReview.aspx

We value your views and comments and will use them to inform the operational process and further improve our service.

07/S0801/93	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Chair

Appendix 9: Research Ethics Committee Amendment

26 September 2008

Mrs Helen Wisdom
Practice Educator
Shetland NHS Board

Dear Mrs Wisdom

Study title:	**Workbased learning - An exploration of the perceptions of mentors supporting pre- registration nursing students in clinical settings**
REC reference:	**07/S0801/93**
Amendment number:	**AM01**
Amendment date:	**23 September 2008**

The above amendment was reviewed at the meeting of the Sub-Committee of the REC comprising the Chair of Committee 1 and the Vice Chair of Committee 1.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Protocol	2	
Participant Information Sheet	1 Logs	18 September 2008
Participant Consent Form: Logs	1	18 September 2008
Mentor Log	1	
Notice of Substantial Amendment (non-CTIMPs)		
Covering Letter		

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

07/S0801/93:	Please quote this number on all correspondence

Yours sincerely

Committee Co-ordinator

Appendix 10: Research Ethics Committee Progress Report

16 October 2008

Mrs Helen Wisdom
Practice Educator

Dear Mrs Wisdom

Study title:	**Workbased learning - An exploration of the perceptions of mentors supporting pre- registration nursing students in clinical settings**
REC reference:	**07/S0801/93**

Thank you for sending the progress report for the above study dated 10/10/2008. The report will be reviewed by the Chair of the Research Ethics Committee, and I will let you know if any further information is requested.

The favourable ethical opinion for the study continues to apply for the duration of the research.

07/S0801/93:	**Please quote this number on all correspondence**

Yours sincerely

Ethics Administrator

NHS
Health Board

Appendix 11: 'Ethical' Contract

WORK BASED LEARNING – AN EXPLORATION OF THE PERCEPTIONS OF MENTORS SUPPORTING PRE-REGISTRATION NURSING STUDENTS IN CLINICAL PRACTICE

I have a responsibility to behave ethically at all times and I will follow the British Educational Research Association's Ethical Guidelines. Permission to conduct the research has been sought from the North of Scotland Research Ethics committee and The Open University's Student research project panel. The research will be registered with The Open University's Data Protection Office and I will comply with good practice regarding the safe storage of data.

As I am a registered nurse I must adhere to The NMC Code of Professional conduct: standards for conduct, performance and ethics (2004). As such I must act upon any information revealed during the course of interview that might indicate poor practice in the workplace. I would inform you of my proposed action should this occur and would encourage you to take appropriate action.

Helen Wisdom	signature	date

Appendix 12 The insider/ outsider continuum (Adapted from Tricia Le Gallais, 2003)

Dimensions: relating to my position on the continuum	Potential advantages and *disadvantages*	Strategies to deal with negative aspects of 'insider' status
Mentors know me and I know them	Rapport established swiftly, enhanced trust and confidence–access to more intimate data. As an insider I may be less intrusive. *'Cosiness' and overfamiliarity might have negative impact on credibility. Role confusion/blurring: researcher vs. employed position as Practice Educator, friend and/or colleague. My senior role in organisation-might influence data as mentors seek to impress/manipulate me. Personal likes and dislike of mentor/researcher might impact at a variety of levels. There might be a reluctance to talk about sensitive issues – or reverse – too easy to use me as a 'counselling service' or sounding board.*	Try to strike a 'balance' during interviews-tap into positive aspects of relationship but maintain some 'distance' e.g. with professional demeanour, location of interviews in a 'neutral' environment if possible, away from clinical settings. I need to adopt a sensitive approach at interview – but try to set clear boundaries. Aware that degree of intimacy/distance may vary with individual mentor. Stress that I seek mentor's perspectives, there being no 'right 'or 'wrong' answers at interview. Acknowledgement of my own feelings about mentors and mentorship – I admire what they do, I feel protective of them, proud of them-how does this colour my research? My interpretation of data may be influenced by my biases. On-going 'dialogue' via my journal to monitor progress of research – acknowledge ways in which I influence the research.
Familiarity with NHS 'culture' and ways of working	In depth knowledge of NHS culture, no 'culture shock' for me, commonly shared language, history of organisation built up over many years *'Too familiar', not able to see important, potentially significant behaviours, accepting this as 'normal'. Inability to 'stand back' as an insider. Assumptions and preconceptions on both sides.*	Constantly ask questions of myself in analysis of data. Aware that I must 'make the familiar strange'. Remind myself that things change and that I have not been in clinical practice for years. Use the 'paradigm model' advocated by Strauss and Corbin to interrogate the data.
Familiarity with role of the mentor	Shared knowledge of the role, respondent/researcher have common experience, shared language/ terminology– enhances flow of dialogue during interview. *Difficult to ask 'stupid' (obvious) questions' – interviewees will assume that I have in-depth knowledge of mentoring; I might assume that my perspective is generally widely held. My personal experience of mentoring was gained years ago this might skew my understanding of current practice.*	During interviews I need to accept that some things are given, there will be a shared understanding at some level. Sharing experiences might develop trust- I can 'check out' my experiences with mentors by questioning them. Remind myself that things have changed and that I do not have experience of all mentors' situations.
Awareness of working environment specific to mentors	Day to day activity of mentor role is understood – there is no need for mentors to use valuable interview time providing minutia of activity for me. *This may lead me to making assumptions. I may misunderstand experience of mentors in diverse small island communities, all with individual 'micro cultures', interpreting their experience through the prism of my similar/ but not exact experience.*	My 'insider' knowledge will always be partial. I must remind myself that 'I don't know what I don't know' and guard against making assumptions.
Other dimensions: Age, gender, educational attainment, social class, social standing/ personal history well known in small community, accent, ethnicity.	Each of these dimensions may give me an 'insider' or 'outsider' relationship with individual mentors and the potential to enhance/ diminish my research, by means of increased/ lack of rapport with respondents. Added complexity in that this varies with each individual and in some dimensions might vary over time, e.g. my personal credibility may enhance/ diminish depending upon actions out with this research – and will always be known in a very small community.	Maintain my awareness that I am a member of myriad 'subcultures' but not in every respect. These are widely defined and may change over the duration of the research.

Appendix 13: Exemplar Diary

Mentor log

Mentor ID _____

Notes on Completion of the log:

- The log is in a week per page view with a space for each day and space for comments. Please use the space at the end of each week for any reflections or the additional sheets at the end of the log if you need more space.
- Please note the types of mentoring activities you have been involved in with your student each day if possible. Please do not identify any students by name.
- Please give the approximate time taken for each activity. There is no need to provide the date.
- Please comment upon how effective you feel your mentoring activities were in supporting student learning in practice. Please comment upon any difficulties that you had in supporting your student, for example, not sufficient time to spend with the student, or any aspects of mentoring that you felt went particularly well.
- Please look at the 'sample page' provided for one possible way of completing the log but don't be constrained by this, please include any activities you consider as mentoring. These might include demonstrating a skill, holding a brief tutorial, discussing a clinical event, observing the student performing an event and giving them feedback.
- This log is your property. I will take a copy for my research project. Data from this log will be anonymised and confidentiality will be assured.

Day	Time	Mentoring Activity	Comments
Monday	2hrs	Met student Orientation to Health centre Set learning objectives	V. useful to have comments from previous mentor - needs to focus on drug administration and dressings
Tuesday	3hrs 2hrs 1hr	Visits, observed me doing leg ulcer dressings,. Afternoon spent with Health visitor Researching leg ulcer treatments on computer	Very busy day, not much time to discuss care with student but she observed me doing range of skills and will undertake leg ulcer dressing tomorrow
Wednesday	3hrs 2hrs	Home visits, observed insulin injections, catheter care, Student undertook leg ulcer dressing Attended case conference	
Thursday			
Friday	My day off	Student with colleague and visiting pharmacy	
Saturday	My day off	Student day off	
Sunday	4hrs 2hrs	Visits, observing palliative care. Student performed oral care and catheter care-I supervised Researched drugs used in patients with CHD	V. busy, short staffed, paperwork to complete in the afternoon.

Comments

We have 3 students allocated this week and 2 people off sick. Don't feel that I have been able to spend as much time as I would like with my student.

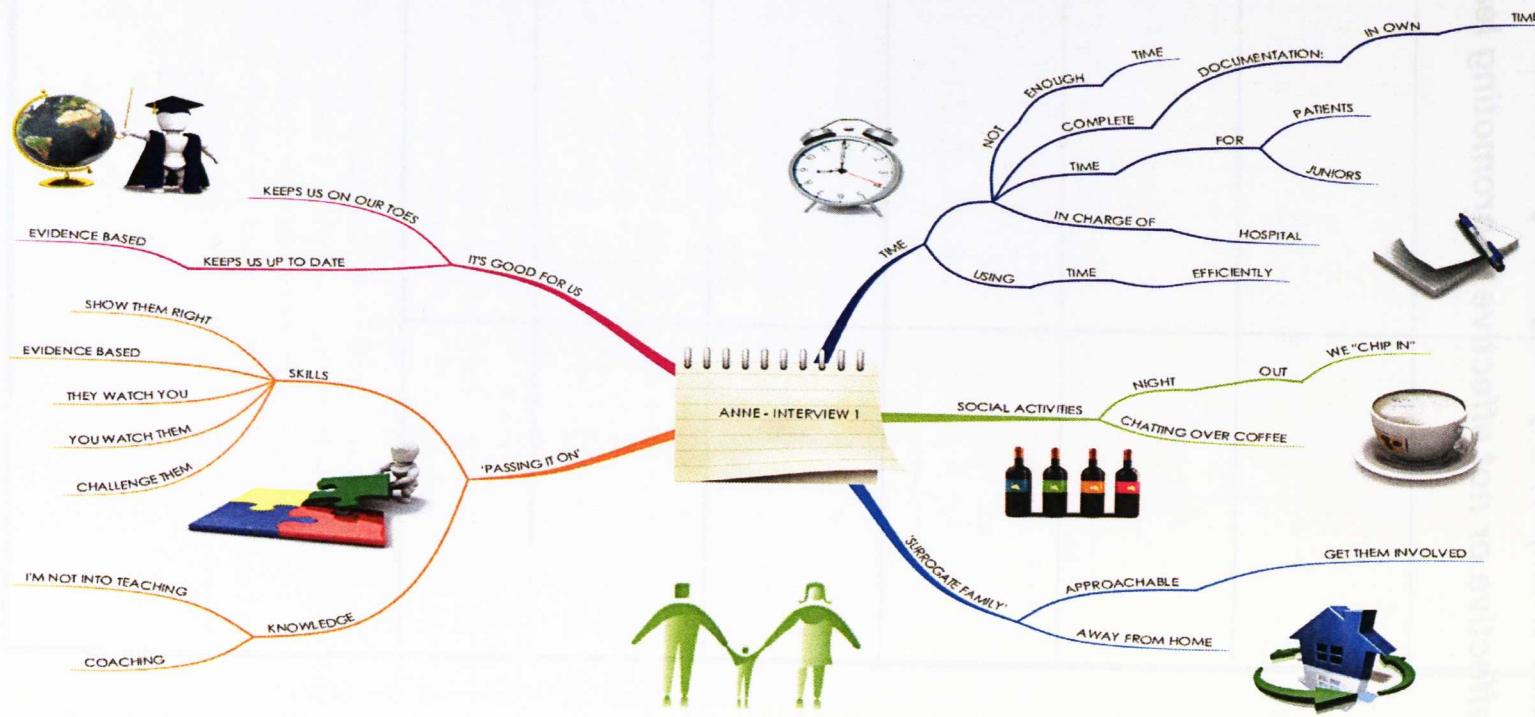
Day	Time	Mentoring Activity	Comments
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			
Comments			

Please use this sheet for any additional reflections you have on your mentoring activities.

(For example, anything that you feel that has been particularly effective or not effective in promoting learning).

Appendix 14: Mind Map (Buzan, 2003)

Interview Summary Mentor 1.1



Appendix 15: Example of Open Coding

	Code	Definition/ Comments
1	Years as mentor	*Years that mentors have been supporting students – taking account of terminology re support mechanisms, which have changed over many years*
2	Time Factors	*Not enough time, clinical pressures and other responsibilities* *Too much time?* *How much time spent with student?*
3	Numbers of students	*How many students and frequency with which mentors support students*
4	Staffing levels	*Staffing establishment/ levels/ skill mix and impact this has upon mentoring arrangements*
5	Social activities	*Social activities involving students, mentors, staff, students, having lunch, coffee with students* *Welcoming students to the team*
6	Being a mentor	*Mentors view of their mentor role*
7	Students are...	*Mentors view of students, broad generalisations about students attitudes, interests, approaches etc.*
8	Challenges	What makes being a mentor a challenge, what factors impact upon the role that make performing it well problematic
9	Mentor needs	Support that mentors identify to enable them to carry out the role effectively
10	'Surrogate family'	'Caring relationships' akin to a family relationship
11	'Good for us'	Aspects of mentorship viewed as being a positive gain

12	'Passing it on'	Passing on knowledge, skills – the 'essence of nursing' as well as 'craft knowledge'
15	Learning experiences we can provide	All the opportunities for learning in clinical practice
16	Other mentors	How mentors view other mentors
17	Mentors view other staff	What impact do other staff members, senior and more junior to mentors have on the mentor experience. Do mentors use other staff to help facilitate learning of their students
20	'First years'	Broad generalisations about junior students
21	Senior students	Broad generalisations about senior students
22	Pacing the learning	Mentors consider how to provide appropriate learning experiences for their students at the various stages in their programme and depending on their personal experience.
23	Clinical skills	Clinical skills available in a particular clinical area
24	Management skills	Types of learning experiences, provided by mentors to give a broader management perspective
26	Identifying student needs	How mentors determine what students need to learn when they arrive in the workplace and then plan to meet those needs
27	Role model	Mentors as role models
28	Encouraging	How mentors engage with students to facilitate learning

29	Approachability	Mentors make themselves amenable to students
30	The means to learn	Opportunities provided for learning across a broad spectrum
31	Reflecting	Mentors helping students to learn from their experiences
32	'You watch them' (Supervising)	Mentors observe students doing a specific task and more broadly in all that they do.
33	Trust	Decisions around what a student may/ may not undertake in a clinical setting Also gaining the trust of the student
34	Assessment	How mentors view their role in assessing student performance- Assessing both formative and summative
35	'They watch you' (Observation)	Students observing mentors doing a specific task and more broadly in all that they do
36	Demonstrating	Mentors demonstrate to students a particular skill or activity
37	Mentor – student relationships	Referring to relationships that may develop, friendships which may endure beyond the placement duration, another dimension to the formal mentor- student relationship/ professional boundaries
38	Mentor – mentor support networks	Support networks that evolve between mentors, both formal and informal. Formal in that a 'deputy' mentor might be appointed, more informally a team approach to mentorship might be adopted
39	Teaching	Situation that could be considered 'formal' teaching sessions, this might include short tutorials, training sessions in the work place (e.g. BLS)

40	'like sponges'	Students soak up the information
41	'What will this one be like?'	Mentors wonder about the student prior to meeting them – will the mentor like the student, will the student be keen to learn, will this be a 'good' student?
42	Shadowing	Students follow mentors
43	Mentor preparation	Formal/ informal education undertaken to prepare for the mentor role
44	'We learn from them'	Examples of how mentors have learned from students
45	Documentation	Placement learning assessment documentation – and completing it
46	Action planning	Plans devised to help students to meet their learning objectives
47	Chatting	informal conversations with students
48	'Showing them right'	Mentors ' knowledge base / adhering to best evidence based practice
49	Like and Enjoy having students	What mentors like/ appreciate about mentoring students (links with 11 – good for us)
50	Theory into practice	Translating book learning into practice
51	'Speak them through'	Giving a running commentary – either in anticipation of the event or during the event 'coaching the students' as mentor and mentee work together
52	Questioning	Probing students' knowledge

Appendix 16: Examples of Coding 'A mother and her child' / 'Sussing them out'

Element	Examples of coding from interview transcripts
'A mother and her child' Mentors' relationships with students – nurturing, supporting, expressed in terms of mothering – a family bond.	*I maybe find the **'mothering'** bit quite easy given my age (laughs).* M1.2 301-302 *Yes, I think because now I am older, I think that I can **mother** them a wee bit and make them feel welcome to ward x, and most of the girls that come to ward x say that they really like it, enjoy it and gain a lot from it, and most of the nurses here are really quite friendly, one or two older ones, we **mother** them. I think it chivvies them along a bit. When I left home myself, I experienced homesickness myself, so then I can share that with them, and tell them how I coped with it. I was phoning home every night but at the same time I was very determined, and I said you just have to be determined and you will get over it, you will be really glad at the end of the day that you have stuck it out and not run away home.* M4.2 126-134 *I have heard other people speak about the **mothering** role and I suppose that it is more **'guardian'** I would say than parental thing but I do try and find out a little bit about the student's kind of personal history and a bit about their back ground because we are all different, we all have our own 'baggage' so if you can understand a bit of what's going on in their life it is kind of easier to help them, you know.. yes, **I would say guardian more than mother.** Having said that… yes, possibly I do speak to the students in the same ways as I do to my daughter so maybe I am more **motherly** than I maybe thought.* M5.2 86-94

	Yes, a very intense relationship, whereas when you have had other children then that intensity diminishes doesn't it? M7.2 25-30 *...it gives you a feeling of 'success' reward almost... when they've reported back that they have had a good time or done their first dressing really well or they look at you like 'was that good or what?' there is that kind of ...**it's almost like growing a baby but not quite (laughs) but almost like that part of it.** M8.1 360-363*
'Sussing them out' Mentors gaining a more holistic view of their students - an understanding of their personal lives	*so I always try and do a bit of an ice breaker and try and get **them to talk about themselves**. An example would be that over the last five years I have had a student nurse who was on lithium tablets, so she needed to drink or another one who was a diabetic. Now, if they are scared of speaking to you, how can they honestly say 'Oh sorry, it's 11 o'clock, I'm feeling a bit unwell, I need to stop and eat or I need a drink of water? You have to make them feel valued as a person within training and I think that historically we've not been very good at that because we just work them to death. M3.2 57-64* *Well I think that you have to be able to really **suss them out**, em.. because I feel that the youngsters nowadays are not maybe as conscientious, what would the word be, you know, they think that they can get off with more. When I was a student, I would never have told a lie or said 'Oh, I was off sick yesterday because I had a pain in my tummy' when maybe they had been out drinking and were lying with a hangover the next day. And, er.. I think if you are maybe a good listener as well, and you hear them chatting with their friends and you get to the truth sometimes about what was really wrong with them. If someone had been off sick at lot, you say to yourself, 'Are they being sick or are they not'. M4.2 253 -261*

	Yes, and this girl's, this last student I had, she seemed to be wanting to go home a lot, and in the end, it seemed that this girl's brother had been taking drugs and I think underneath it was troubling her, ***and sometimes we would have a wee heart to heart talk and she would say,*** *'Oh, I'm just a wee bit worried about my brother', and I mean, I have nephews that take drugs and so I says, 'I have nephews that take drugs and I am quite worried about them',* ***and then she opened up to me.*** *She didn't want to tell me about that but then she opened up to me, and she told me that this was what her brother was doing. I think there is still a bit of stigma attached to people who take drugs, they don't want to speak about it, because ... but we sort of got to the bottom of her brother. M4.2 263-272* *I think it won't be quite so intense. I think that the student won't have me all day, every day, em... and if they are staying in the accommodation I will be actually driving them to the workplace so we will have 10-15 minutes each day that is not work conversation* ***so I think that I will get to know them socially a bit more*** *M5.2 235-238.* *I think the first week you really just have to be supportive and kind of let them weigh you up,* ***because we are weighing them up from the minute they come in the door.*** *And it quite often takes the student about a week to come out of their shell and be themselves you can see the first few days they are on egg shells and saying what they think you want to hear. Em... and that's fine in some ways but it is very false, so I think that first week really the most important thing is to support them M6.1 493-499* *Yes, it was trying to be not just a mentor but trying to offer support and guidance* ***because I knew there were things going on at home M9.2 43-45***

Appendix 17 Data Gathering and Analysis

Research question arising from literature review - 'What role do mentors play in facilitating learning in clinical practice?'

Regional research ethics committee approval sought and granted

Advertise throughout Health Board Area seeking volunteers for mentors on locally held mentor register

10 mentor volunteers recruited to the study and formal consent obtained

Data gathering –'first-round' interviews:-

Alex Betty Chris* Dora Emma Fiona Gloria Heather Irene

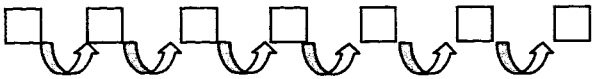
Each interview:
Audio recorded
Transcribed
Summarised
} Open coding

* Diary completed as part of Year I pilot

Constant comparison – memos written – describe and chart development of codes

Data gathering by diaries:- [Order depends upon student allocation]

Alex Emma Fiona Gloria Irene Heather Dora

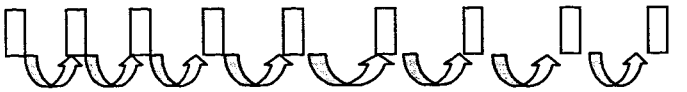


Each diary:
Transcribed
Summarised
} Open

Constant comparison – memos written – describe and chart development of codes

Data gathering – 'second- round'

Irene Chris Alex Fiona Heather Gloria Jacqueline Emma Dora



Each interview:
Audio recorded
Transcribed
Summarised
} Open coding

Constant comparison – memos written – describe and chart development of codes

Open

Focused coding establishing links between codes

Tentative theory

'Fostering Student Learning'

Directs data collection in later interviews

Appendix 18 Core mentoring activities identified from diaries

Core activities	Examples of mentoring activity identified in diaries
Specific clinical skills/ techniques	Assisting student in setting up syringe driver/ removing clips/ removal of wound drain Observed student dressing wound/ bandaging techniques/ catheterising/ cavity dressing/ applying compression hosiery. Mentor carrying out catheterisation and bladder washout – student observing Student observed chemotherapy Bed bath in HDU Drug round with student, I.M. injections Setting up McKinley pump
Inter-professional activities	Introduction to care home, discussing relationship with community nursing team. Care of patient in VF – anaesthetic team required Student discussion with Macmillan nurse Student to theatre – observing procedures (ophthalmology)
Management	Introduction to keeping weekly diaries and planning case loads Student given management rota Discussion relating to importance of notes and stock availability Submitting timesheets
Professional knowledge underpinning practice	Discussion of blood tests and importance in diabetes Wound care in community settings – discussion of compliance in home setting Discussion of spotting ill child and fits using e-learning tool. Discussion of medicines in A&E Reviewing critical incidents Discussion of student 'work-book'/discussion with student regarding progress Plaster training/ Leg care and Doppler training including sign guidelines. Discussion of technique of feeding patient after bowel surgery Tutorial on lymphatic system and oedema How to access online learning materials/policies relating to case load/ Reviewing case notes

Appendix 19: Draft Student Charter

STUDENT CHARTER

On '*Placement name*' *Jane Smith* can expect:

- *To be allocated a mentor and co-mentor to support learning*
- *A duty rota that provides a minimum of 40% mentor contact time, taking account of reasonable 'off duty' requests*
- *Supernumerary status and a commitment that he/she will not be moved to another area unless agreed as part of a 'pathway' to meet identified learning needs*
- *Learning needs to be discussed and documented within 48hrs of commencing placement with mentor or co-mentor*
- *Access to a range of learning experiences*
- *An environment that is welcoming and supportive of learning in which you can feel part of the team*
- *A team approach to support*
- *Regular feedback on performance and progress that is documented in a timely manner*
- *Fair and objective assessment that is recorded in Placement Documentation*
- *Access to support from the wider team such as PEF and PEL and other confidential support services*

Jane Smith is expected to:

- *Contribute as a partner in achieving learning outcomes, being pro-active in addressing learning needs*
- *Raise any concerns about practice placement experience in a timely manner*
- *Evaluate his/her practice placement experience*
- *Adhere to the uniform policy*
- *Inform mentor or ward manger when unable to attend placement due to sickness or other reason*
- *Adhere to agreed duty rota and change shift patterns only with express agreement of mentor*

Signature *Jane Smith*

Mentor *Mary White*